WAR AND HEALTH INSURANCE POLICY IN JAPAN AND THE UNITED STATES

World War II to Postwar Reconstruction

TAKAKAZU YAMAGISHI

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The Johns Hopkins University Press
Baltimore

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Printed in the United States of America on acid-free paper
2 4 6 8 9 7 5 3 1

The Johns Hopkins University Press
2715 North Charles Street
Baltimore, Maryland 21218-4363
www.press.jhu.edu

Library of Congress Cataloging-in-Publication Data
Yamagishi, Takakazu, 1972–
War and health insurance policy in Japan and the United States : World War II to postwar reconstruction / Takakazu Yamagishi.
p. cm.
Includes bibliographical references and index.
ISBN-13: 978-1-4214-0068-6 (hardcover : alk. paper)
ISBN-10: 1-4214-0068-5 (hardcover : alk. paper)
1. Medical policy—United States—History—20th century. 2. Health insurance—United States—History—20th century. 3. Medical policy—Japan—History—20th century. 4. Health insurance—Japan—History—20th century. 5. World War, 1939–1945—Medical care—United States. 6. World War, 1939–1945—Medical care—Japan. I. Title.
RA395.A3Y36 2011
368.38′200973—dc22 2010046801

A catalog record for this book is available from the British Library.

Special discounts are available for bulk purchases of this book. For more information, please contact Special Sales at 410-516-6936 or specialsales@press.jhu.edu.

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For Yuka, Chikara, Kazushi,
and my parents, Shigeo and Michiyo Yamagishi

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Preface

I grew up and currently live in Japan, but I lived in the United States for about eight years. When I was at the Johns Hopkins University studying for my doctoral degree, I played softball on the political science team. Once, while running to catch a ball, I felt a sharp pain in my knee. It turned out that I had hurt a knee ligament and had to see a doctor. At that time, I knew almost nothing about the American health insurance system. At the outpatient reception desk, a lady in front of me became upset and left the hospital, apparently due to a problem with her health insurance. In Japan, the first question a person is usually asked is, "Is there anything wrong with you today?" Only later would you be asked, "Could I have your insurance card?" In contrast, in the United States, one of the first questions posed is, "What kind of health insurance do you have?"

In Japan, there are many public health insurance programs. But no matter what health insurance program we belong to, we can basically get medical treatment by any doctor and in any hospital. In the United States, on the other hand, the health insurance you have decides where you can go for medical treatment. As a Japanese man, I was puzzled by this. Patients do not have the freedom to choose their doctors and hospitals in the United States, where I assumed such freedom was guaranteed.

Is American health care bad? Many Japanese friends who came to study at the Johns Hopkins University medical school have told me that it is not. American medical technology is the choice not only of scholars and professionals in the field of medicine but also of patients, including many affluent people and members of royalty all over the world. My wonderment at the American health care only deepened. My experiences in America provided me with a potential book topic: Why did Japan and the United States adopt the health care systems they have? I began to pay attention to one of the core elements of the health care system: health insurance.

I belong to the school of American Political Development, which I would describe as comparative studies in the field of American politics. APD compares not only periods in U.S. history to one another but also the United States to other countries. Alexis de Tocqueville, who compared European countries, including his own country, France, and the United States, is often named as one of the first APD scholars. APD students use comparison to see what cannot usually be seen. This approach inspired me, as a Japanese scholar, to study the development of health insurance in the United States by comparing it with the practice in Japan.

As I wrote this book, Japan and the United States were both facing a considerable degree of pressure to reform their health care systems. Because of Japan's high longevity rate and low health care expenditures, some have singled out the Japanese health care system as a model of effectiveness and efficiency. But the situation is not so straightforward. In recent years there have been many reports on the lack of doctors at hospitals, particularly in the areas of obstetrics/gynecology and pediatrics. In August 2006, a pregnant woman in Nara Prefecture who had suffered a brain hemorrhage died in the ambulance after being rejected by nineteen hospitals.[1] While such cases are still occurring, many hospitals have closed down because of financial difficulties and the shortage of doctors.[2] The government is now facing pressure to deal with health care reform, particularly the shortage of doctors and low doctors' fees. In his first policy speech on June 11, 2010, Prime Minister Kan Naoto said that his administration "will work to rebuild the medical system, and to secure medical care that inspires confidence."[3]

On the other side of the Pacific Ocean, the United States also suffers from health care problems. While the United States has very high health care expenditures and perhaps the most developed medical technology, many Americans do not have access to quality medical treatment simply because they cannot afford it. Moreover, in the past few decades, even those with private health insurance have difficulties receiving the requisite care. Health care reform was one of the most important issues in the 2008 presidential election.

On February 4, 2009, as one of his first legislative acts as president, Barack H. Obama signed a bill to add nearly $33 billion over five years to the State Children's Health Insurance Programs (SCHIP). He had followed through on his promises from the electoral campaign, suggesting that the legislation would be the first step toward universal coverage. Then, on January 27, 2010, in his State of the Union speech held in the U.S. Congress, Obama said, "By the time I'm finished speaking tonight, more Americans will have lost their health insurance.

Millions will lose it this year. Our deficit will grow. Premiums will go up. Patients will be denied the care they need. Small business owners will continue to drop coverage altogether. I will not walk away from these Americans, and neither should the people in this chamber."[4] On March 23, 2010, Obama signed the Patient Protection and Affordable Care Act into law, and on March 30 he signed the Health Care and Education Reconciliation Act of 2010. By these, Obama sought to establish a near-universal health insurance system, although there is no guarantee that he has won the battle; the outcome depends a great deal on the newly elected Republican House and the 2012 presidential election.

What is amazing is that the health care reforms in Japan and the United States are moving in the opposite direction. History matters to the future course of health care reform. How health care policy, institutions, and interest groups have developed in the past affects the current state of health care politics. To have a more complete understanding of health care history, it is important not only to study what exists in a country but also to discern what is not visible.

When we are healthy, many of us hardly think about being injured or sick, nor study our own health care system, nor volunteer to research foreign health care systems. When we become injured and sick, we are generally too weak and tired to give serious thought to our health care system. But our life, in both length and quality, depends largely on what kind of health care system we have. I hope this book arouses interest in readers, because few of us avoid being a patient at one time or another.

According to Japanese custom, I have adopted the order of surname first and given name last for Japanese nationals in the text. Where English sources have Japanese authors, I have placed surnames last.

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Acknowledgments

With this, my first book, I remember all the important mentors, friends, and family members who helped me get here. I was born in a rural area of Japan, Fukui Prefecture, where we were rarely exposed to foreign people and cultures. But my parents, Shigeo and Michiyo Yamagishi, helped me to open as many windows of curiosity as possible. When I was young, my mother always told me that I should study three times as hard as others if I wanted to become whatever I wished. My father, who had had to give up his college education for financial reasons, has always supported me during my long years of graduate work. My two brothers, Yoshinori and Katsuaki Yamagishi, were always my rivals. I remember when we three boys worked hard together in a small study room.

When I started undergraduate work at Keio University in Japan, I was very excited, but at the same time I was overwhelmed by the big metropolitan city, Tokyo. Fumiaki Kubo, my mentor at Keio, rescued me from the great sea of students and helped get me interested in academic studies, in particular American politics. Among many friends, I developed a healthy competitive rivalry with Takeya Matsuzaki and Yotaro Okamoto; we cheered each other up in the American politics seminar.

After a one-year break, I enrolled in the master's program of Keio University. Fumiaki Kubo was again my mentor. Now that I am a professor, I have adopted his way of advising. He first established a relationship of trust with his students and then straightforwardly criticized our work so that we students felt pressure to improve our work. For the first time in my life, I engaged seriously in academic work. Although there were some tough times, I rather enjoyed studying, thanks to friends like Sona Kim, Yuri Tamori, and Takahiro Endo.

I longed to pursue doctoral work in the United States, because I had never lived there before and I wanted to experience firsthand what the United States is all about. I was wondering if any doctoral program would accept a Japanese student of American politics with limited English skills. The Johns Hopkins

University was my savior. One of the first courses I attended was Matthew Crenson's "America as a Foreign Country." Crenson stressed the importance of studying the United States from comparative perspectives. He also got me interested in studies of social policy. He became my advisor and helped me to complete the program.

After my first year, Adam Sheingate arrived at Johns Hopkins; he soon became another important mentor. I can say absolutely that I could not have completed my doctoral dissertation without his immense support, imagination, friendship, and patience. He shared Crenson's belief in the importance of seeing the United States from comparative views. He also gave me the opportunity to focus on health care policy. It was profoundly reassuring that he welcomed me so warmly whenever I knocked at the door of his office and discussed my half-baked ideas with such stamina and interest. He also kindly read all of the chapters of this book at a very early stage.

At Johns Hopkins, I received support and advice from many other professors, including Mark Blyth, William Connolly, Joseph Cooper, Andrew Cherlin, Erin Chung, Steven David, Benjamin Ginsberg, Richard Katz, Daniel Kryder, Siba Grovogui, Nan Astone, Kelly Tsai, and Thomas Thornton. Milton Cummings warmly encouraged me to visit his office and discuss American politics. Sadly, he has since passed away, but he was a fine teacher, scholar, and person.

Many friends supplied the inspiration, energy, and, on occasion, healing I needed to get through the graduate program at Johns Hopkins. They include Erin Ackerman, Ray Anderson, Michael Boda, David Burgess, Jinline Chang, Lynda Cross, Thomas Donohue, Donald Duedes, Constance Fowler, Curtis Fowler, Takashi Fujimoto, Yumie Fujimoto, Nozomu Kawai, Ellen Keith, Kaori Lindeman, Lily Lui, Yasushi Matsuoka, Terukazu Morikawa, Koichi Okada, Nobutaka Otobe, Sacrament Rosello, Ariel Roth, Marisa Sheingate, Stephen Stich, Lynne Stewart, Asami Takagi, Shu Takagi, Lynne Stuart, Lars Tønder, Hanne Thornton, Maria Vassileva, Akiko Yamamoto, Hirofumi Yamazaki, Vera Zamboneli, and Julie Zeng.

After I came to teach at Nanzan University in Japan, I was again blessed to have wonderful colleagues and friends who supported my efforts to complete this book, including Hiroshi Fujimoto, Toru Hanaki, Masaki Kawashima, Noboru Kinoshita, Yoshimitsu Miyakawa, Yuki Ooi, David Potter, Tatsuya Suzuki, and Ve-Yin Tee. Ichiro Iwano and David Mayer read the entire manuscript and gave me valuable feedback. As the principal officer of the American Consulate in Nagoya, Jonas Stuart made it possible for me to meet scholars and other prominent figures from the United States. My research assistant, Junko Ito,

was instrumental in my being able to complete the publication process. Finally, I had the good fortune to have many great students at Nanzan University. They have consistently shown great curiosity about the United States and supplied many interesting perspectives, many of which made me see my project in a new light.

Other people and institutions helped make this book possible. I have presented part of this book in workshops and conferences, where I received many helpful comments from prominent scholars including Taku Amano, John Campbell, Jun Furuya, Marie Gottschalk, Takeshi Igarashi, Rieko Kage, Robert Lieberman, Theodore Marmor, Koji Nakakita, Hiroshi Okayama, Elizabeth Sanders, Bartholomew Sparrow, Takashi Suganuma, Yoneyuki Sugita, Kensuke Takayasu, and Masaharu Yasuoka. In particular, John Campbell gave me a long list of suggestions to improve my project at the end of one conference.

I received support from many institutions. First, the Rotary International Foundation gave me a fellowship to start studying in the United States. The Johns Hopkins University gave me a generous four-and-a-half-year financial support to pursue the doctoral program. Matsushita International Foundation gave me a fellowship to do research for my doctoral dissertation. Nanzan University also provided a Pache Fellowship for my research from 2007 to 2011. Lastly, I have had two grants, Grand-in Aid for Young Scientists (Start-up [20830116] and B [22730128]) from the Ministry of Education, Sports, Science and Technology of Japan, which helped me to complete this book.

Earlier versions of portions of this research have been published previously in English as "Occupation Politics: American Interests and the Struggle over Health Insurance in Postwar Japan," *Social Science History* 30, no. 1 (Spring 2006); and "Public, Private, or Neither? Strategic Choices by the American Medical Association toward Health Insurance from the 1910s to 1940s," *Academia Humanities and Social Sciences* 86 (January 2008).

To publish this book, I also had assistance from Suzanne Flinchbaugh and Henry Tom at the Johns Hopkins University Press and copy editor Martin Schneider. Their guidance and patience helped a first-timer like me a lot. There are many more people who have guided me to this point of my life, but I cannot name them all here because of the limited space. But I would like to thank all who touched my life and helped me to write my first academic book. I could not have done it alone. All errors and omissions are my own fault.

Lastly, I thank my own family. In my third year at Johns Hopkins, I met my wife, Yuka. My life changed after that. She made my life in the United States much happier, changing graduate school life from a climb on a rocky mountain

to a picnic on a beautiful hill. I also knew how the "real" American health care worked by talking with her because she was a resident of the pediatric dentistry program at the University of Maryland at that time. We have had two sons, Chikara and Kazushi. Without their love and smiles, not only would this book not have been possible but I also would not be as happy as I am.

War and Health Insurance Policy in Japan and the United States

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Introduction

Approximately fifty million people died in World War II. Yet, despite this massive devastation, the war was also responsible for policies that would improve the health of people. World War II forced nations like Japan and the United States to realize that healthy soldiers, workers, mothers, and children were vital for their survival. Health insurance, which assured people's access to medical care, became a means of building up national strength in wartime. Whereas before the war, Japan and the United States lagged behind major European countries in terms of health insurance coverage, by the end of the postwar reconstruction both had become much closer to being the forerunners. That relationship, between total war and health insurance in Japan and the United States, is the focus of this book.

The term *total war* describes the condition in which every aspect of the country comes under the influence of the war. In such circumstances, governments pursue comprehensive economic and social policies for war mobilization. Before the twentieth century, it was mainly the professional soldiers who fought wars, while the rest of the population remained relatively untouched by the government's mobilization activities. With the advent of total war, such as in World War II, military conflict had a profound effect on nearly all parts of the economy, society, and politics.

The question this book explores is: How did World War II shape the health insurance systems of Japan and the United States? Both countries increased their health insurance coverage during the war and in the postwar reconstruction. In the total war of World War II, wider human resources and materials

were mobilized, and health insurance was connected with national security in both countries.[1] The government found health insurance useful for enhancing war mobilization, and the war allowed the government to have more power to expand health insurance coverage. The wartime political, policy, and ideological changes were so great that they also affected the development of health insurance during the postwar reconstruction.

While both Japan and the United States expanded their health insurance coverage, they adopted different health insurance systems.[2] This discrepancy resulted from the variations within the total war and the postwar reconstruction. In 1952, when the U.S. military occupation of Japan ended, Japan had a health insurance system that was predominantly public and was composed of multiple programs. In contrast, when President Harry S Truman decided not to campaign for reelection in 1952, the United States had a health insurance system that relied greatly on private health insurance. I claim that these different outcomes resulted largely from the dissimilarities between the two countries' war experiences, such as the duration and depth of mobilization, the sequence of the war, and the result of the war. All these factors greatly influenced what kind of health insurance system developed in each country.[3]

It was during the period under study that Japan and the United States consolidated the developmental path of their health insurance, public-dominant in the one and private-majority in the other. After the American occupation ended, Japan achieved universal coverage in 1961. The basis of its health insurance system has remained the same up to the present day. The central government directly administered a program for workers in small companies, which targeted 27.7% of the population in 2006. About 3,400 insurers, including municipalities (1,835) and firm- or occupation-based mutual associations (1,561), provided public health insurance coverage for other citizens.[4] The Ministry of Health, Labor, and Welfare (formerly the Ministry of Health and Welfare and the Ministry of Labor) plays a role in supervising these programs.

On the other hand, among OECD countries, the United States is the only industrialized country in which the government does not guarantee universal health insurance coverage for its people and in which a significant segment of the population relies on private health insurance. Although two major public health insurance programs, Medicaid and Medicare, were created in 1965 for the poor (12.9% of the population in 2006) and the aged and the disabled (13.6%), respectively, private health insurance is the main component of the American health insurance system. In 2006, 67.9% of Americans were enrolled in private health insurance programs. But there is a large segment of the

population that neither public nor private health insurance covers: about 47 million people (15.8%) remain uninsured.[5]

What happened from World War II to postwar reconstruction influenced what kind of health care problems each country had and how the political struggles over health care reform took place in the subsequent period. In showing the formative process of the current health insurance systems of Japan and the United States, this book reveals the institutional and political background of the current problems in health insurance. One of the most serious challenges for Japan at present is to deal with such problems as increased medical costs brought about by an increasingly aging society and the financial weakness of some public health insurance programs. On the other hand, the United States has had to address the two problems of rising health care costs and the large number of people who do not have health insurance. In both countries, there are efforts to push for drastic reform, while groups with a stake in the current health care system have put up fierce resistance.

Edwin Amenta has called social policy "lines of state action to reduce income insecurity and to provide minimum standards of income and service and thus to reduce inequality."[6] Health care is one of the key components of the social safety net, and health insurance is crucial in deciding who gets health care in what form. When people get sick, it is an unexpected event. How they recover from the sickness and return to normal life—in other words, how much they worry about unexpected medical procedures—depends largely on what kind of health insurance system their countries foster.

EXISTING APPROACHES

Formal Political Structures

Some scholars attribute the differences of health insurance systems to the degree of centralization in the formal political structures. According to them, the more centralized a political structure a nation has, the more easily it can pass a sweeping social policy like universal health insurance. Sven Steinmo and Johns Watts, for example, have demonstrated that it is very difficult to enact ambitious reforms in the United States because of its fragmented political structure. On the federal level, the separation of powers spreads political power among the executive, legislative, and judicial branches. On the state level, federalism constitutionally causes the federal government and state governments to share sovereignty.[7] Moreover, the congressional system furthers the fragmentation of American political structure. Chairs of committees and subcommittees,

who have a large influence on policymaking, are more independent from their party leaders than their counterparts in the parliamentary system.[8]

The Japanese political structure is more centralized than the American one. In 1889, Japan proclaimed its first constitution, known as the Meiji Constitution, which gave the emperor supreme power. Although the Constitution stipulated the separation of powers among the executive, legislative, and judicial branches, the emperor held ultimate power over all of them. In 1947, during the U.S.-led military occupation, Japan adopted its second constitution, in which the emperor is situated as the symbol of the nation, and sovereignty now essentially belongs to the people. The head of the majority party in the Diet is usually appointed prime minister. Therefore, as in other parliamentary systems, the prime minister has a stronger connection with the Diet than the American president has with Congress. Furthermore, alliances between the bureaucrats and the majority-party politicians produce a more top-down policymaking process in Japan.[9]

That a centralized political structure is better at producing radical reforms than a fragmented one seems reasonable enough. But it is not always true. Jacob Hacker has pointed out that a fragmented political structure does not always hinder the development of a universal health insurance program. Canada, for example, achieved universal coverage under the federal system in 1966. Universal health insurance can be achieved not only by creating a single centralized program in which the federal government has a strong authority but also, like Canada, by loosely incorporating local programs.[10] Additionally, while a centralized political structure may be good at passing this or that large-scale policy, it may also be good at ignoring demands for one. Thus, formal political structure alone cannot explain policy outcomes.

Interest Groups

A second set of arguments involves the role of interest groups and their capacity to promote or block legislative proposals. This approach assumes that policies result from political struggles among interest groups. In health care, two interest groups especially gain scholarly attention: labor unions and medical associations. This approach concludes that when there are strong labor unions and weak medical associations, a nation is more likely to adopt universal health insurance.

Organized labor is generally considered to support the government's initiative to expand the safety net. Some Marxist scholars claim that the power of

organized labor, especially in its connection to social democratic parties, is the central measure in understanding the development of the welfare state. By this argument, in countries where organized labor has strong political power, the government tends to play an active role in advancing public health insurance.[11]

Another important interest group is associations of doctors. Medical associations in general are active in preventing perceived government interventions in the relationship between doctors and patients, especially the care doctors provide to their patients and the fees they charge. Because the government cannot implement health care policies without the cooperation of doctors, medical associations play an important role in the policy process.

This argument might be used to explain why the United States, which has more fragmented labor unions and a stronger national medical association, has a less generous social policy than Scandinavian countries. But the argument faces a difficulty in understanding the differences between Japan and the United States, because both countries have weak organized labor and a strong national medical association. The United States is a country that historically has a low level of union participation and has lacked an enduring nationwide socialist party.[12] Although Japan has political parties in the Diet that support socialism and communism, they were peripheral in the face of the longstanding dominance of the Liberal Democratic Party after World War II. As a result, organized labor plays a less powerful role in the policymaking process. T. J. Pempel and Keiichi Tsunekawa have called Japan's system "corporatism without labor."[13]

Moreover, both Japan and the United States have a strong national medical association. Many scholars have pointed out that the American Medical Association has historically been active in blocking public health insurance legislation.[14] The Japan Medical Association is also known, especially from 1957 to 1982, when Takemi Taro was its president, as an interest group with a strong influence on national health care legislation.[15] Despite these similarities, Japan and the United States have different health insurance systems. Therefore, any approach that focuses on the struggle among interest groups cannot fully account for the differences in the two health insurance systems.

Political Culture

A third group of scholars claims that a country's political culture affects the development of social policy. But where does political culture come from? This cultural argument usually assumes that the origins of a nation's political regime largely influence its culture. By determining how social problems are explained

and defined, according to this group, political culture can influence the content and scope of the policy alternatives under consideration.

Louis Hartz, for example, has claimed that the United States has a dominant liberal culture because it was founded by separating itself not only from British authority but also from European feudalism altogether.[16] Alexis de Tocqueville's words ring behind his analysis: "They [Americans] were born equal instead of becoming so."[17] As Seymour Lipset noted: "The American Revolution sharply weakened the *noblesse oblige*, hierarchically rooted, organic community values which had been linked to Tory sentiments, and enormously strengthened the individualistic, egalitarian, and anti-statist ones which had been present in the settler and religious background of the colonies."[18] Because of these American values, Lipset concluded, Americans tend to oppose a social policy that leads to the expansion of government authority.

Japan experienced a different path of state formation. After a long feudal history, Japan did not sever its ties to feudalism by physically separating from the old regime. Continuity rather than discontinuity was emphasized during the revolution, because, as the term Meiji Restoration implies, the Japanese revolution would return governmental authority to the emperor.[19] As a result, Lipset wrote, "Japan has modernized economically while retaining many aspects of its preindustrial feudal culture."[20] Lipset's conclusion is that because of their historical background, the Japanese have stronger status consciousness, are more group-oriented, and exhibit deeper Tory-statist tendencies.[21] With these cultural prejudices in place, it can be concluded that the Japanese would be less reluctant to accept government-initiated social policies than the United States.

Political culture may explain the rough characteristics of a nation's social policies. According to this third approach, the United States, with its individualistic culture, has a health insurance system that relies largely on private health insurance, while Japan, with a more group-oriented culture, has a health insurance system that depends mostly on public programs. However, because the cultural argument tends to consider a culture as static, the cultural approach does not sufficiently explain why reform occurs in a certain period. Neither can it comprehend the roles a government plays in the administration of health insurance. For example, this approach cannot explain why Great Britain, with its more liberal culture, has a more administratively centralized public health insurance system than Japan, which relies more on the private sector for the administration of the programs.[22]

Policy Feedback

As Paul Pierson has written, "Over time 'the road not chosen' becomes an increasingly distant, increasingly unreachable alternative."[23] This is the point of departure for the fourth group of scholars, who claim that historical processes, specifically the timing and sequence of events, shape politics and policy. Compared with the first three approaches, this group admits more historical contingency to explain policy development than the other approaches. One of the key elements to understanding the role of timing and sequence in political development is the positive feedback mechanisms that produce path-dependent outcomes in politics. Path dependence typically refers to a condition in which past policy development constrains the range of alternatives in subsequent periods.

There are two types of feedback mechanism that produce path-dependent outcomes. The first type may be described as learning or adaptation effects. Over time, actors form preferences, adjust expectations, and develop proficiencies in response to the institutional, political, or policy contexts they inhabit. The oft-cited example of such learning effects is the adoption of the QWERTY typewriter keyboard. QWERTY is not the most efficient keyboard arrangement, but the early adoption of QWERTY by typewriter manufacturers produced a situation in which people were disinclined to switch to an alternative because of the cost of replacing equipment and retraining workers. Applied to politics, one might find learning effects in the way citizens' expectations conform to existing policies or in the way bureaucrats follow standard operating procedures in identifying problems and choosing solutions. As in the case of QWERTY, such adaptations may make change prohibitively costly or undesirable.[24]

A second type of feedback mechanism may be described as the effect of political configurations. Policies have distributional consequences for different groups in society. In addition, policies create groups with an interest in the status quo, such as program beneficiaries and bureaucratic agencies in the case of social policies. Like learning effects, political configurations may hinder policy or institutional change. But unlike learning effects, change becomes unlikely because vested interests defend the status quo. Because legal force is behind political institutions and policies, according to Paul Pierson, feedback mechanism in politics is more rigid than in economic activities.[25]

Jacob Hacker has shown that once private health insurance grew, the AMA joined labor, business, and insurance providers in pushing for its further expansion as an alternative to public health insurance. As a result, it became more

difficult for the United States to introduce universal health insurance.[26] Kawakami Takeshi has also shown that after major public health insurance programs were created in Japan during World War II, bureaucrats and the JMA saw them as a given, such that abolishing them never became an option in their minds.[27]

While policy feedback mechanisms have gained much attention among policy scholars, less studied is how policy feedback starts in the first place. Scholars argue that policy feedback occurs after significant changes—often precipitated by some external event such as an economic crisis or war—happen in policy development, changes that bring opportunities for sweeping changes in society. The period when the range of policy alternatives momentarily widens is called a critical juncture.[28] What we need to study further is what kind of policy alternatives critical events bring about.

Formal political structure, interest groups, political culture, and policy feedback all have to be taken into account in answering this question. In response to a worldwide economic depression, for example, nations with centralized political structures have a capacity to react more quickly than ones with fragmented political structures. Furthermore, a public with an authoritarian culture and weak organized labor should more likely accept the government's control of the economy than one with a liberal culture and strong organized labor. It should also be easier for the government to expand existing programs in response to urgency than to create a new policy from scratch.

However, understanding why nations adopt certain policies in response to critical events is far from straightforward. While the formal political structure, interest groups, political culture, and policies influence policy outcomes, critical events can transform all of them into a new shape. Moreover, critical events do not affect all countries the same way. This point is driven home with the simple question: Did the United States experience the same depression in the 1930s that other countries did? Obviously it did not. Different economic crises affect formal political structure, political culture, and other political factors differently. Thus, we have to consider not only the static situations nations were in when critical junctures occurred—such as what is written in the constitution—but also the ways that different degrees of crisis affect the institutions and policies that nations have. To study these yet-unexplored questions allows us to understand how the positive feedback sequences begin to unfold. The next section discusses these issues in detail by referring to the studies that deal with a specific kind of critical event—total war.

TOTAL WAR AS AN IMPORTANT FACTOR

In 1996, Gregory Kasza wrote, "Since war is among the state's primary functions and modern wars have witnessed unprecedented levels of mobilization and destruction, this question should be central in comparative research, but it is not."[29] The same can be said for Japan and the United States. In 1998, Shō Kashin noted that Japanese scholars have neglected the impact of total war on the development of social policy in Japan.[30] Moreover, in 2002 Ira Katznelson and Martin Shefter and in 2005 David Mayhew pointed out that scholars who study American politics had disregarded how war influenced domestic political development.[31] Although the following studies deal with the relationship between war and social policy, we still need a more comprehensive analytical framework.

Richard Titmuss was one of the first scholars to examine war and social policy seriously. In the 1950s, Titmuss argued that World War I and World War II, which he called modern wars (in this book, total wars), led Great Britain to expand its social policies. For instance, the policies to improve the health of soldiers and workers were vital for military ends as well as for munitions production. Furthermore, because total war made morale as important as physical health, Titmuss noted that "the war could not be won unless millions of ordinary people, in Britain and overseas, were convinced that we had something better to offer than had our enemies."[32] Because of these factors, he argued, the British government tried to assure better public services and more equal treatment for its people. His single-case study, however, did not lead others to focus on the impact of war as the main factor in comparative studies of social policy development.

Nearly forty years later, Gregory Kasza offered an explanation for why social policy scholars have neglected to deal with the impact of war. First, they find it difficult to theorize war's influence because wars are seen as exceptional events with unique consequences for long-term social policy development. Second, academia generally has a liberal or Marxist orientation consistent with the belief that popular demand or class struggle is a consistent factor in social policy development. Third, scholars who experience wars seek a "return to normalcy" in their lives and avoid war research.[33] Specifically for Japan, furthermore, Shō also noted that Japanese scholars have been reluctant to include war as a central factor in their social policy studies, because the Marxist view was until recently dominant in Japanese academia.[34]

Kasza and Shō reexamined Titmuss's question about the relationship between war and social policy by looking at the case of Japan. They showed that

World War II created new political institutions and social policies in Japan. The government created a new ministry, the Ministry of Health and Welfare, to integrate health care and welfare administration. The war also brought Japan new social policies, such as programs providing health insurance, old-age pensions, relief for the poor, and housing. Just as Titmuss had established for Britain, Kasza and Shō concluded that the Japanese government had needed these policies for pursuing the war.[35]

Figure I.1 summarizes Kasza and Shō's arguments about how total war leads to the expansion of health insurance. Total war provides an incentive for the government to produce policies for improving the health and morale of the people. While in total war the government of course needs healthy soldiers in the battlefields, it also must have reliable industrial and agricultural workers who support the soldiers by producing food and munitions. The government, furthermore, regards those who do not work—including the unemployed, the aged, and housewives—as human resources for the war because they can replace workers who may be moved to the battlefields. Finally, as long as it remains uncertain when a total war will be over, the government makes plans to improve the health of women, who can give birth to future soldiers and workers. In order to strengthen the nation's manpower, therefore, the government must produce policies to improve the health of all people.

In order to make war mobilization more efficient and to win a total war, the government must improve not only the physical health but also the morale of its country's people. Total war cannot be won without the people's enduring support and sacrifice, as measured in time, money, and, of course, lives. In fact, the government's actions to improve morale are intertwined with its policy for the health of the population. Total war needs support not only from the elite class or professional soldiers but also from other segments of the population.

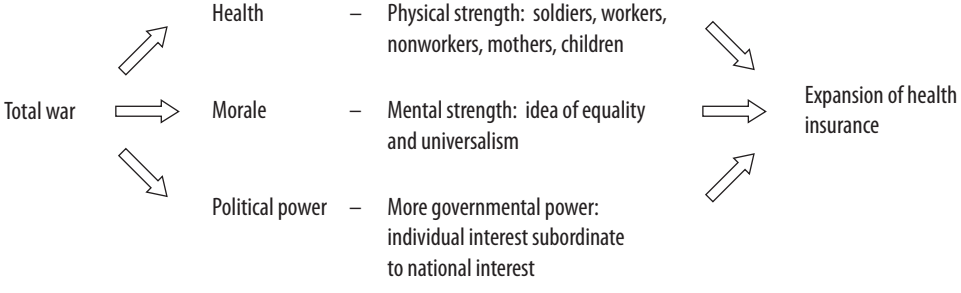
Total war
Health – Physical strength: soldiers, workers, nonworkers, mothers, children
Morale – Mental strength: idea of equality and universalism
Political power – More governmental power: individual interest subordinate to national interest
Expansion of health insurance

Figure I.1. Total war and health insurance.

To motivate its people for the war, the government must spread the idea of equality and universalism; otherwise, neglected groups may dissent from the government's war activities. The government, therefore, has to make policies for improving solidarity. In this regard, health insurance becomes a tool for the government to improve the nation's manpower and the nation's morale.

While total war gives the government incentives to get involved in its people's physical and mental strength, it also gives the government more power to do so. In fear of defeat, which may mean the termination of a country, selfish interests become subordinate to the national goal, which is winning the war. In total war the government has the legitimacy to change political institutions and policies for achieving the national goal. Furthermore, in total war, interest groups refrain from pushing through their interests with the same fervency. For example, medical associations do not press their claim for controlling doctors' practices and fees, and they are more likely to accept the government's intervention in these matters.

These propositions by Kasza and Shō need to be advanced by the addition of three analytical dimensions for studying the impact of total war on health insurance. First, a comparative perspective. Because Kasza and Shō's studies are all single-case studies, they provided only a limited lens to discern how a nation's institutional and political factors influence policy outcomes. Works by Daniel Kryder and Jytte Klausen help solve this problem. With an implicit comparative perspective, Kryder studied how World War II influenced racial policy in the United States. Race issues, according to him, became salient during the war because war conscription and the war economy brought a large segment of the black population into the military and industrial arenas. To mitigate racial tensions, the federal government produced policies that benefited African Americans. Kryder concluded that because of the fragmented nature of the American political structure, wartime racial policy became more diffuse than what could have been done under a more centralized political structure.[36]

For her part, Klausen demonstrated why World War II caused social economic policies in some countries and other policies in others. By comparing the United Kingdom, Sweden, Germany, Austria, France, and the United States, Klausen claimed that formal political structure, political culture, preexisting policies, and party and interest group politics need to be taken into account in the variations of policy outcomes.[37] Kryder and Klausen have both shown that policy innovations influenced by the war did not occur in an institutional and political vacuum.

Second, the uniqueness of the Japanese war. Although Kasza and Shō paid scrupulous attention to how war mobilization efforts led the government to get

involved in social policy, few scholars have emphasized the distinctive characteristics of the Japanese war. How does the Japanese experience of World War II differ from the wartime experiences of the United States and other countries? How did those differences influence policy outcomes? The work of John Dryzek and Robert Goodin helps answer these questions. They quantitatively demonstrate that nations' different war experiences during the 1930s and 1940s were responsible for different levels in social security expenditure. They measured several factors that indicate the degree of social uncertainty caused by the war, such as the number of casualties, the war's duration, and economic conditions. They concluded that level of social security expenditure was directly correlated with the degree of social uncertainty a nation experienced during the war.[38] Their study demonstrates that the differences in national war experiences matter for social policy development.

Richard Bensel's findings support this conclusion. Bensel showed that during the American Civil War, the Confederacy, which had supported states rights against a strong central authority, adopted an even more centralized political structure and a more generous social policy than the northern Union because the Confederacy experienced a more devastating war. Moreover, if compared state by state, the states closer to the front line adopted a more statist political structure.[39] Although his case is not strictly speaking an international war, Bensel confirms that the nature of war affected political structures, political culture, and social policies. To comprehend what kind of health insurance policies evolved, therefore, we must look into the differences in the nations' war experiences.[40]

Third, the postwar period. Neither Kasza nor Shō dealt with the postwar period. Titmuss asserted that total war has long-term consequences: wartime social policy "must influence the aims and content of social policies not only during the war itself but in peace-time as well."[41] Klausen's work confirms that World War II caused innovations in social policy that persisted after the war. But policy innovations do not automatically cause the necessary learning effects and new political configurations. Wartime changes, after all, can be either reversed, maintained, or accelerated on a case-by-case basis. The case study in this book stresses that how feedback mechanisms unfolded—in other words, how enduring wartime policies were—depended not only on the wartime policy at issue but also on the degree of devastation caused by the war.

World War II, a total war, led to the development of social policy.[42] To find out why each country adopted a different policy, many scholars have focused on political structures, interest group politics, political cultures, and preexisting

policies. But a few scholars have argued that different policies were created because each nation had different war experiences. Being in the latter group and studying both wartime and postwar reconstruction, I focus in this book on the effects of World War II on political structures, interest group politics, political cultures, and policies of health insurance in Japan and the United States. World War II opened a window for a new set of health insurance policy choices and led each nation down a policy path that was then consolidated.

WHY JAPAN AND THE UNITED STATES?

This book examines the cases of Japan and the United States in relation to the effect of total war on health insurance systems for two reasons. First, unlike the major European countries, neither Japan nor the United States had mature health insurance coverage when they entered World War II. For example, in Britain 43.1% of the population had health insurance coverage in 1937. By contrast, only 5.4% and 9.3% were covered in Japan and the United States, respectively. Figure I.2 shows how Japan and the United States expanded their health insurance coverage by 1952. In light of the policy feedback argument, the trajectory path of health insurance policy development was more indeterminable before the war in Japan and the United States than in European countries.

Second, the Japan-U.S. comparison offers a unique historical interaction between the two countries as a result of the American-led military occupation in Japan from 1945 to 1952. In fact, the American authorities played a role in consolidating different health insurance systems in Japan and the United States. This interaction, therefore, provides us with a distinctive opportunity to study how the same (American) interests and policy ideas were turned into different policy outcomes under different conditions with respect to formal political structure, interest group politics, political culture, preexisting health insurance policies, and different postwar circumstances.

When the United States is compared with Japan, skeptics may point out that these comparative cases are invalid because Japan and the United States are often used to illustrate the different cases / different outcomes argument. They would emphasize the differences in the political structures and political cultures of the two countries during World War II, more centralized and authoritarian in Japan than in the United States. They would conclude that the different policy outcomes resulted from the differences in political structure and culture. As I have argued above, however, this interpretation shows only half of the picture. Moreover, this way of thinking prevents us from examining how World

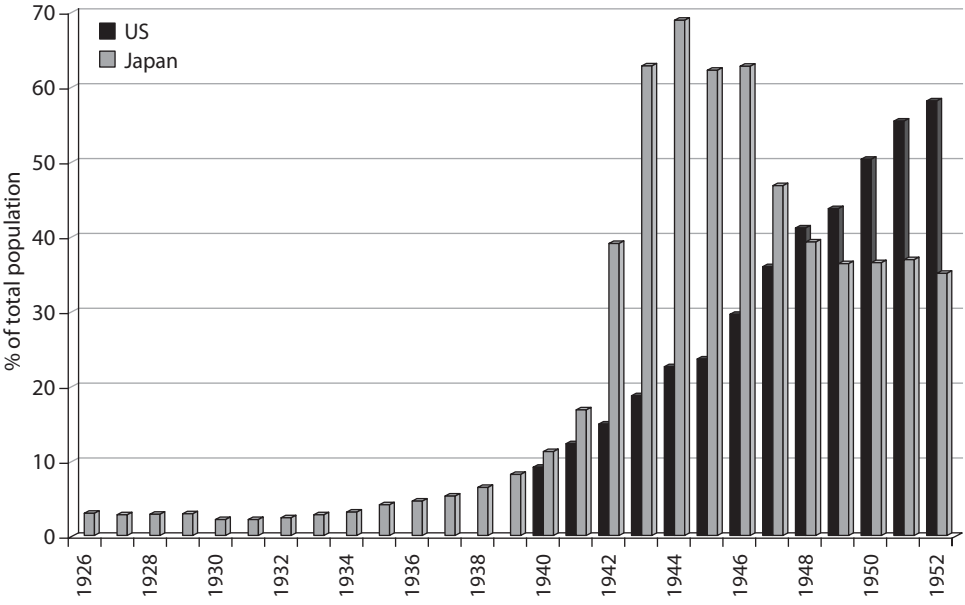

Figure I.2. The expansion of health insurance coverage in Japan and the United States, 1926–1952.
Sources: Kōseishō Gojūnenshi Henshū Iinkai, *Kōseishō Gojūnenshi: Shiryō Hen,* 869–74; and U.S. Department of Commerce, Bureau of the Census, *Historical Statistics of the United States, Colonial Times to 1970*, 82.
Note: For Japan, the numbers are total enrollees in the Health Insurance, the National Health Insurance, and the Seamen's Insurance. For the United States, the number is total enrollees in private plans. Since the VA health care targeted not only service-related incidents but also non-service-related ones, it is difficult to estimate who actually could be called a VA health care enrollee. Therefore, the numbers do not include VA health care beneficiaries.

War II changed the political structure and culture of both countries into being more statist, why both countries similarly expanded health insurance coverage at the same period, and why they adopted health insurance systems. The U.S.-Japan comparison offers answers to these questions.

Consequently, part I concerns the political structure, political culture, interests of medicine, and health insurance that developed in Japan (chapter 1) and the United States (chapter 2) before World War II. Part II discusses how World War II influenced the development of health insurance in Japan (chapter 3) and the United States (chapter 4). Japan's situation comes before that of the United States in parts I and II because the comparison with Japan gives us another way of understanding how the United States acted in response to its health needs during the war. Part III explores how the wartime policy and institutional development along with the devastation from the war affected the postwar policy development in the United States (chapter 5) and Japan (chapter 6). Part III

reverses the order of the countries because it is important to understand what political and institutional development occurred in U.S. health care in that period to comprehend what influence the American-led occupation had on Japan's health insurance. Parts I, II, and III each have an introduction that explains more of my analytical framework. Those who have a strong interest in my theoretical argument should read them first.

This book seeks to provide a new perspective for understanding the development of health insurance in Japan and the United States. As Seymour Lipset pointed out, both Japan and the United States are considered unique or exceptional countries.[43] Niki Ryu has also affirmed that the current Japanese and American health care systems are both extreme cases and that the European countries are all somewhere between the two poles.[44] That perspective is partly why scholars have pursued only limited comparative studies of health care in Japan and the United States. This book, however, demonstrates that the U.S.-Japan comparison gives us a new perspective with which to understand development of health insurance in each country and in others as well.

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CHAPTER ONE

Learning from Germany

Japan before 1937

In 1868, the government of the Tokugawa Shogunate ended 268 years of rule. After it abolished the feudal social and political system, the new Japanese government sought to modernize Japan by emulating Western countries. The government designed its new constitution, military system, and industrial policy by learning from them. The idea of health insurance also came to Japan, and the government created some public programs that targeted selected groups. But this did not result in swift expansion of health insurance coverage. One of the important opposing forces was the medical profession, as represented by medical associations. This chapter describes the formation of medical associations and then shows how health insurance development in Japan was limited by their influence before World War II.

THE DEVELOPMENT OF THE JAPAN MEDICAL ASSOCIATION

Until the collapse of the Tokugawa Shogunate, the Shogunate government maintained its isolationist policy, which limited its contacts with other countries. Under the isolationist policy, Japan had developed its own medicine, *Kanpō,* which had largely been influenced by Chinese medicine since the tenth century and had been combined with ancient Japanese techniques. After the Meiji government took control in 1868 and adopted a program of modernization, doctors who had training in Europe sought to eliminate *Kanpō* medicine by labeling it as "less scientific" medicine. This movement was related to the birth of medical associations.

Westernizing Japanese Medicine

In Japan, the development of medical associations was advanced by doctors practicing Western-style medicine. They sought to eliminate *Kanpō* medicine, which by the end of the Tokugawa Shogunate had become dominant. The Japanese called doctors *kusushi* (apothecaries), which meant specialists in the prescription of medicine. The doctors charged for medication based on the herbs used but did not seek payment for clinical diagnosis. *Kanpō* stressed the balance of energy (*ki*), blood (*ketsu*), and bodily fluids (*sui*) rather than the treatment of specific parts of the body based on scientific methods of diagnosis.[1] The Tokugawa Shogunate government officially endorsed *Kanpō,* while doctors called *rangakui* who practiced medicine developed in Europe were in the minority.[2]

Although *Kanpō* was the official medical treatment under the Tokugawa Shogunate, the Shogunate government did not intervene much in its practice, for instance in quality control. Medical education was nothing like what Japan adopted after the Meiji government made efforts to improve it. Primitive medical schools existed in the Shogunate Era, often as a part of temples. But, even worse, only some doctors were trained there. Other doctors began to practice after only a brief period of training under senior doctors without basic formal education. In December 1868, the newly created Meiji government stated, "Although doctors have a serious responsibility for human life, it has been heard that there have been doctors who prescribed and prepared medicine without having had any medical education at all."[3]

In 1869, when it issued the Approval for Western-Style Medicine (Seiyō Ijutsu Sashiyurushi), the Meiji government officially recognized the medical contributions of Europe. This was prompted in part by the government's difficulties in providing adequate surgical procedures for the soldiers injured in the conflict with the Tokugawa forces. Ōmura Masujirō, a military surgeon general, claimed that "Japanese medicine has to be Westernized. Chinese medicine is useless in military hospitals."[4] Encouragement of Western-style medicine also fit the overall priorities of the new Meiji government to catch up with the European countries by adopting a new legal system, developing industry, increasing military power, and ultimately abolishing unequal treaties that favored the West. Westernizing medicine was part of the government's effort to enrich the nation and build up national defense (*fukoku kyōhei*).[5]

In order to spread and improve Western-style medicine, the government regulated medical education. There were great differences in the level of education

among doctors who practiced Western-style medicine. While some doctors had formal medical education—many of them had studied in Europe—other doctors had little or no education beyond a cursory study of prescriptions.[6] To make progress in medical education, in 1877 the Meiji government created the Tokyo Imperial University's medical faculty as the top institution of the medical education system. Other medical schools had to hire Tokyo Imperial University graduates in order to be recognized as official institutions. Meanwhile, the government regulated the licensing system. In 1879, the government required doctors to pass a common examination created by the Home Ministry.[7] But because this system still allowed doctors to take the examination without a formal education, the elite doctors and the government worked together to create the Medical Practitioners Law (Ishi Hō) in 1906.[8] Under this law, all new doctors were required to graduate from an official medical school or medical vocational school in order to be licensed.[9]

Because of these regulations, the number of doctors trained in Western-style medicine grew rapidly. The Ministry of Education (Monbushō) noted that in 1874, doctors in Western-style medicine were only 19% of the total, while those in Chinese medicine accounted for the other 81%.[10] By 1896, however, doctors studying Western-style medicine had increased to 36%.[11] By 1925, it was estimated that the figure had reached 90%.[12]

Although the government played a large role in promoting Western-style medicine, total nationalization of medicine was not its true end. Private clinics, hospitals, and doctors were the main suppliers of care for ordinary people. The Medical Rules and Regulations (Isei), which were released to the municipalities in 1875, stipulated that doctors could open clinics and hospitals anywhere, with the government's almost automatic permission; this was called in Japanese *jiyū kaigyōi sei*, which basically allowed doctors to open their clinics and hospitals no matter how close together they were.[13] Furthermore, with the government's decision not to engage with public clinics and hospitals, private clinics and hospitals grew. In 1881, Finance Minister Matsuoka Masayoshi issued a deflation policy that included a provision stating that the prefecture governments were not allowed to use local taxes for prefecture and city hospitals.[14] This discouraged the development of public hospitals and resulted in the development of private hospitals. In 1877, private hospitals accounted for 22% of all hospitals (35 of 159). But by 1898, that proportion had increased to 75% (465 of 624).[15] As a result, by the turn of the century, Japan was relying on Western-style medicine, private hospitals and clinics, and private practitioners to maintain the health of the population.

The Creation of the Japan Medical Association

Interests in medicine were organized in tandem with the westernization and the professionalization of medicine. Those who had training in Western-style medicine sought to eliminate *Kanpō,* which they thought was unscientific and unprofessional. Once *Kanpō* became an absolute minority by the early twentieth century, doctors of Western-style medicine began to press the government to provide medical associations with a formal legal status in order to strengthen their political power. Meanwhile, the medical associations felt the government's pressure to lower doctors' fees so that more people could have access to medical care. By the 1930s, the JMA became a formidable interest group by fighting with *Kanpō* doctors, gaining legal status, and resisting the government, which was seeking to reduce and then control doctors' fees.

In the late nineteenth century, Japan saw the rise of regional medical associations. In 1875, the Medical Society (Igaku Kaisha) was established as the first organization by practitioners of Western-style medicine. It was a combination of a medical study association and a lobbying group. Then the Tokyo Medical Association (Tokyo Ikai) was formed in 1886 by the graduates of Tokyo Imperial University, and it became the most prominent of the earliest regional medical associations. Local medical societies were soon created in other prefectures.[16]

The development of the medical associations that promoted Western-style medicine was a response to the rise of associations that sought to retain *Kanpō* medicine. In 1879 Onchisha was formed by leading *Kanpō* doctors, such as Azai Kokkan and Yamada Gyōkō. In response to the government's initiatives to promote western-style medicine, Onchisha tried to make an alliance with local *Kanpō* organizations. But because their efforts could not change the situation, Onchisha was dissolved in 1887. *Kanpō* doctors made a final serious effort by forming the Imperial Medical Association (Teikoku Ikai) when the newly established Imperial Diet came into operation in 1890. But the result was the same. The First Sino-Japanese War in 1894 was an additional setback to *Kanpō,* because *Kanpō* had originated in the enemy nation. The movement to maintain Chinese medicine died in 1898 when Teikoku Ikai was dissolved and Azai, its longtime leader, died.[17]

In addition to the fight with *Kanpō* doctors, practitioners of Western-style medicine had another reason to promote their solidarity. As described, it had been the tradition since the Shogunate Era that doctors could write drug prescriptions and sell drugs in their offices. They did not charge for diagnosis; they charged only for medicine. Against this tradition, a pharmacist group in 1916

proposed to separate the sale of medicine from other medical services. To doctors, this proposal would have been a financial disaster. The doctors' battle against pharmacists urged Kitazato Shibasaburō, the founder of Keio University's medical faculty, to take the lead in forming the Greater Japan Medical Association (Dainippon Ishikai) that same year.[18]

The leaders of the Greater Japan Medical Association were not satisfied, however, because it was still a voluntarily association without legal status. Their next goal was to have a legal basis for the association. For the JMA, that process would increase its authority over doctors. Fortunately, the creation of the JMA was also beneficial to the government administratively. The Home Ministry had a stake in maintaining a cooperative relationship with the medical associations to implement its own health care policies. With an amendment of the Medical Practitioners Law (Ishi Hō), the Greater Japan Medical Association was dissolved and the Japan Medical Association came into being in November 1923. Kitazato became the first president of the JMA.[19]

William E. Steslicke wrote about the relationship between the government and the JMA after 1923: "The legal organization of the medical world remained essentially the same until 1942. During this period the national Japan Medical Association was given some degree of independence in regulating the affairs of the medical profession depending on the times and the issues involved. It was by no means autonomous or self-regulating, however."[20] It would be hard to determine how autonomous the JMA was before the war. Professional interest groups play different roles in the policy process from other kinds of interest groups because the government needs the former to implement its health care policies. Furthermore, doctors have medical knowledge that is needed for policymaking. Even if the government and the JMA had an intimate relationship, it meant not only that the government had a large unilateral influence on the JMA but also that the JMA always affected the policy process.

In sum, doctors were first mobilized by the competition between Western-style medicine and *Kanpō*. After the defeat of the latter became clear, elite doctors trained in Western-style medicine sought to create a national association and to secure a legal status. By the 1930s, the JMA had become an influential interest group that cooperated with the government to plan and implement medical policy. But soon the JMA and the government clashed over mechanisms that controlled and lowered doctors' fees, such as health insurance and clinics that provided care at lower cost.

LIMITED PROTECTION FOR THE SICK AND DISABLED

At the turn of the century, most industrial workers in urban areas did not have sufficient medical care because it was too expensive. Many farmers in rural areas also lacked access to care for the same reason and also because many villages did not have doctors. Japan's medical practitioner system that allowed private medical providers to practice wherever they wanted could not respond to these problems effectively. Many doctors moved away from rural areas to practice in urban areas, which had more middle-class people.[21] In the early twentieth century, there emerged movements, both on the grassroots level and within the government, to seek a solution to the problem of medical care in rural areas.

Private Measures

Observing that the government had not worked effectively to alleviate the health problems of industrial and agricultural workers, some private firms created private health insurance in the form of firm-based mutual associations, and some farmers began medical cooperatives. Furthermore, some clinics and hospitals began to offer medical care at lower costs than individual private practitioners.

Kanebō, a large manufacturer of textiles, was one of the pioneers among the private mutual associations. In 1905, Mutō Sanji, who had studied in the United States and later became the president of Kanebō, played a major role in creating the Kanebō Mutual Association (Kanebō Kyōsai Kumiai). All employees were required to participate in the mutual association and contribute 3% of their wages, and the employer matched the fund by paying at least half of the employee's total contribution. Along with life insurance and a pension, the mutual association provided hospital and medical care to members at no extra expense as long as they received care in assigned facilities.[22] With the government's promotion of private mutual associations during World War I, by 1920 about 600 private mutual associations existed in factories and about 170 in mining firms.[23]

Private health insurance also emerged in agricultural areas as medical cooperatives (*iryō riyō kumiai*). Farmers began forming the medical cooperatives out of self-protection. When agricultural workers and their families became sick, they went to *Kanpō* doctors. But the number of villages without doctors increased in the late nineteenth century because the new government policies prevented licensing of doctors trained exclusively in *Kanpō*. Doctors with

expertise in Western-style medicine tended to practice in urban areas because of the higher-income patients, better medical technology, and better financial resources.[24]

The lack of doctors in rural areas and the increasing medical costs resulted in the formation of farmers' medical cooperatives. In 1919, a medical cooperative in Shimane Prefecture was the first to provide its members, mainly farmers, with medical care. Some cooperatives built their own medical facilities and invited doctors on a temporary or permanent basis. The medical cooperatives grew after the Industrial Cooperative Law (Sangyō Kumiai Hō), which had been created in 1900 on the model of German system, began to cover medical cooperatives in 1922. Christian reformers Nitobe Inazō and Kagawa Toyohiko also took the lead to expand medical cooperatives. The Tokyo Medical Cooperative, which they founded in 1932, became the most prominent. The number of medical cooperatives, after having increased from 4 in 1924 to 22 in 1931, skyrocketed to 819 in 1936.[25]

As the mutual associations in private firms and the medical cooperatives in rural areas developed, some clinics emerged in urban areas to offer medical care at lower cost. Although not technically health insurance, the clinics shared the same goal: making medical service more accessible to the people. In 1911, the Home Ministry permitted Suzuki Umeshirō and Katō Tokijirō to open an "actual expense" clinic (*jippi shinryōjo*) in Tokyo. The actual expense clinic set doctors' fees for medicine and medical care, initially at about one-third of those set by local medical associations. The medical associations initially took a wait-and-see attitude toward the clinic because they thought that it would not have a big impact. But as the actual expense clinic spread to the other regions, they began to oppose it more vigorously because it was taking patients from them and lowering average doctors' fees. In 1915, the medical associations succeeded in pushing the Home Ministry to restrict further expansion of the clinics. It prevented further expansion of private actual expense clinics, but the Home Ministry continued to allow the existing private clinics and the establishment of public actual expense clinics so that by 1929 the number of clinics increased to 153.[26]

In sum, private measures to protect the people from medical catastrophe emerged in the early twentieth century. Firm-based private health insurance developed in response to the existing health care system's inability to respond to the needs of the people. In addition, medical cooperatives and actual expense clinics were created for the same reason. At the beginning of these developments, medical associations did not have a consistent attitude toward these

private measures. But as their number increased and the government's interest in promoting the health care institutions grew, the medical associations realized that these institutions would have a negative impact on doctors' finances and decisively opposed their further development.

Public Measures

As private health insurance developed, the government expanded its focus from public health to health care finance and, subsequently, from the promotion of private plans to the creation of a public health insurance program for industrial workers. In the early twentieth century, the government produced both health care programs for the families of servicemen and veterans and compensation laws for industrial workers. In 1922, with the support of the JMA, the government passed the Health Insurance Law (Kenkōhoken Hō), a national health insurance program for manual workers, including workers in small firms that did not yet have mutual associations. After seeing how the Health Insurance Law was implemented, however, the JMA concluded that public health insurance could bring nothing but harm to doctors, so it decisively opposed further expansion of public health insurance.

As soon as it was established in 1868, the Meiji government started dealing with public health issues because the spread of epidemic diseases posed a threat to the social order. Largely because civil wars, such as the Boshin War and the Seinan War, caused large migrations of people, diseases such as smallpox and cholera spread over many regions.[27] Moreover, by ending a long isolationist policy under the Tokugawa Shogunate, Japan was exposed to new diseases through trade and international war.

The public health problems resulted in the creation of the Medical Care Division in the Ministry of Education in 1872, which was promoted to the Medical Care Bureau in the following year. In 1875, public health administration, which was originally located in the Ministry of Education, moved to the Home Ministry and became the Public Health Bureau. This organizational promotion and reorganization encouraged the study of health care. One of the first big projects for the Public Health Bureau was the problem of epidemic diseases during the Seinan War in 1877.[28]

The Russo-Japanese War (1904–1905) and World War I (1915–1918) provided other opportunities for the government to expand its role in health care. In April 1904, two months after the start of the Russo-Japanese War, the government created the Assistance for Low-Ranking Soldiers' Family Law (Kashi-

heisotsu Kazoku Fujo Rei) to provide the poor families of low-ranking soldiers with public benefits, including medical care. In 1906, the Veterans' Accommodation Law (Haiheiin Hō) was passed to provide public accommodation for veterans who had permanent service connected disabilities.[29]

When Japan entered World War I, Mutō Sanji, now president of Kanebō, sent a prospectus to the government to suggest that the government increase compensation to veterans and their families. In 1917, in response to his idea, the government introduced a bill to the Imperial Diet. The bill was passed as the Military Relief Law (Gunji Kyūgo Hō). In addition to the measures that had been included in the Assistance for Low-Ranking Soldiers' Family Law, it provided public assistance—including job, career, medical, and maternal assistance—for poor injured veterans and their families. The law led the Home Ministry to upgrade the relief administration for both military-related personnel as well as ordinary citizens by creating the Relief Division (Kyūgo Ka).[30]

While the government developed public health and health care policies for military-related personnel, some government officials went abroad to study western political systems and policies. Among them, Gotō Shinpei was especially inspired by the health insurance programs for workers that Chancellor Otto von Bismarck had introduced in Germany.[31] In 1892, after Gotō came back to Japan, he made a speech proposing the Workers' Sickness Insurance Law (Rōdōsha Shippei no Hoken Hō). He presented the facts of deteriorating worker health in Japan and called for a compulsory health insurance program because "workers' temporary sickness . . . eventually weakens a nation's manpower."[32] Gotō's plan was never realized because the government concluded that the hygiene problem of factories was more urgent.[33] Sugaya Akira noted that "Goto's proposals were rejected many times. But they were not in vain . . . his idea had a large impact on the discussion about health insurance in the following years."[34]

Gotō's idea began to be partly realized as the creation of mutual associations in state-owned firms, which imitated the ones in private firms. The Imperial Railroad Aid Association (Teikoku Tetsudō Kyūsai Kumiai) was established in 1907 due to Gotō's leadership.[35] Although only work-related disabilities were initially covered under the plan, non-work-related disabilities were added in 1916. The workers' contribution was 3% of their wages, and the government's was 2%. The mutual association concept spread to other state-owned firms, to the extent that almost all of them had mutual associations by the end of World War I.[36]

In 1911 the Imperial Diet passed the Factory Law (Kōjō Hō), a workers' compensation program. Soon after the Ministry of Agriculture and Commerce was

created in 1881, it began to study the conditions of factories and their workers. Their plan to create a workers' compensation program came into being as the Factory Law after it became clear that many workers were suffering from the strain imposed by rapid economic growth and the sharp increase in labor strikes: from 9 (1,339 participants) in 1903 to 57 (10,938 participants) in 1907.[37]

The Factory Law targeted private firms of more than fifteen employees, such as mining and spinning factories, many of which required their employees to work long hours in poor conditions. The main part of the law limited working hours, but the statute also included a provision that those firms must offer their employees medical care, without any employee contribution, for work-connected disabilities.[38] In addition to Gotō's support, the rise of socialism influenced its passage. The government saw it as a mediating policy between employers and workers. Many large firms also supported it partly because they sought to weaken smaller firms by making the maintenance of working conditions more expensive. The government initially provided loose supervision over the implementation of the program, but it got more actively involved in the program by the end of World War I.[39]

Also in 1911, another governmental action took place. The Social Welfare Organization's Saiseikai Imperial Gift Foundation (Onshi Zaidan Saiseikai) began to operate hospitals with the support of Imperial and corporate donations and with the government's supervision. It offered medical services to indigent and low-income workers initially for free and later for a small fee.[40] Together with the private actual expense clinics, the Saiseikai Imperial Gift Foundation played a role in helping people who could not afford medical care under the medical system, which was largely based on private practitioners.

These efforts, however, did not cause a drastic improvement in the health of industrial workers. In 1913, at the annual meeting of the National Medicine Association, Ishihara Osamu gave a speech with the title "Female Workers and Tuberculosis." He publicized the deteriorating health conditions of factory workers, especially female workers in spinning factories.[41] Workers' health was increasingly an important part of the national agenda.

The movement to create national health insurance advanced when the Kenseikai Party, a large opposition party in the Diet, presented its plan for workers' health insurance in January 1920. Japan had something close to a two-party system from 1918 to 1932. While the Kenseikai Party (established in 1916, it became the Minseitō Party in 1927) relied on the urban population, the Seiyūkai Party, a conservative majority party, had strong support in rural areas. In an-

ticipation of full male suffrage, the Kenseikai Party sought to propose a more progressive policy for industrial workers to attract their electoral support.[42]

To compete with the Kenseikai Party's plan, the government established the Labor Division in the Home Ministry in August 1920 to study health insurance. The Labor Division submitted an outline of a national health insurance bill in November 1921 and consulted with the Workers' Insurance Investigation Committee (Rōdōhoken Chōsakai). Shimizu Gen, who played a central role in writing the government's health insurance bill, also confirmed that party politics were part of the reason that a national health insurance program for workers became an important part of the government's agenda.[43]

The Greater Japan Medical Association (GJMA) lent its support, if not very enthusiastically, to this proposal. There were four reasons why the JMA tolerated this proposal. First, to doctors, the coverage by the new public program seemed to be too small to have a large impact on the traditional fee-for-service system that most individual practitioners relied on.[44] Second, the GJMA thought that the new public program would set doctors' fees higher those offered by the actual expense clinics. The proposed public program seemed preferable to a private rival.[45] Third, leaders among Western-style doctors used the new public health insurance for workers to expand their influence on other doctors. The government paid fees to local medical associations based on the number of patients, and the JMA decided the doctors' fees. The elite doctors sought to control the fee schedule and strengthen its leadership. Lastly, the GJMA sought to increase its influence on the government's policymaking process. Some government officials actually worried that the new program would make doctors more politically influential. Kitajima Taichi, later president of the JMA, discussed the bill with the government from its very early stages.[46]

In March 1922, the Imperial Diet passed the Health Insurance Law (Kenkōhoken Hō). Yamamoto Tatsuo, the minister of agriculture and commerce, explained that the aim of the Health Insurance Law was "to solve the conflict between capital and labor, which would strengthen Japanese industry in international competition."[47] The rising pressure of labor unions helped the Health Insurance Law pass with "surprising speed."[48] Party politics between Seiyūkai, the majority party at the time, and Kenseikai also played a large role in the creation of the Health Insurance Law. During the early 1920s, it was expected that male suffrage would be achieved in the near future. After the Kenseikai began to use health insurance proposals to appeal to the new future voters, the government also had to do the same.[49]

The Health Insurance Law targeted those who were covered by the Mining Law (Kōgyō Hō) and the Factory Law.[50] It covered all costs for sickness, injury, death, and maternity care for workers whose annual income was 1,200 yen or more. The government offered up to 2 yen for each insured worker, money that was to be used for administration costs. The health insurance premium was divided in half between employers and employees, and workers paid no more than 3% of their wages for the insurance premium.[51]

The Health Insurance Law had two components. The first was the Association-Managed Health Insurance (AMHI, Kumiai Kanshō Hoken), which incorporated the mutual associations in private firms as insurers with public supervision. The government allowed employers with more than three hundred full-time workers to establish their own health insurance associations with the government subsidy. It could also compel employers with more than five hundred employees to do so. Under the AMHI, each insurer had the freedom to have its own clinic and set its own health insurance medical fees. The other component in the Health Insurance Law was the Government-Managed Health Insurance (GMHI, Seifi Kanshō Hoken). The GMHI covered those who worked for smaller firms with more than fifteen employees. In contrast to the AMHI, the government was the sole insurer in this program and annually negotiated with the JMA for the total amount of the budget.[52]

The Health Insurance Law also caused institutional development in heath care administration. In response to the passage of the Health Insurance Law, in November 1922 the government created the Social Affairs Bureau as an extra-ministerial body to the Home Ministry. Health insurance affairs moved from the Labor Division in the Ministry of Agriculture and Commerce to the Social Affairs Bureau. In June 1923, the Health Insurance Division in the Social Affairs Bureau was created to prepare for implementing the Health Insurance Law. Although the Great Kantō Earthquake in September 1923 delayed the policy implementation, the Health Insurance Law came into operation in April 1927 under the administration of the Health Insurance Division.[53]

However, the Health Insurance Law soon became unpopular among various groups. First, after it was implemented, doctors complained that the Health Insurance Law fees were not sufficient and that the paperwork was too complicated.[54] Second, the insured workers were dissatisfied with the Health Insurance Law because some doctors refused to see the insured or were reluctant to offer adequate care and because they now had to pay the premium for work-related disabilities, which the Factory Law had covered without workers' contribution.[55] Third, large businesses complained that their employees abused

the Health Insurance Law, and smaller businesses complained that the Health Insurance Law put a greater burden on them than on large companies, because the former were often financially weaker than the latter.[56]

The discontent of many interest groups made it difficult for the Health Insurance Law to expand its coverage after implementation; only 4.9% of the population were enrolled in the program in 1936. It only covered workers in certain industrial sectors and included neither family members nor the agricultural workers who were the dominant workforce at that time. The government's authority remained limited to administering the Health Insurance Law. Although the government was responsible for setting the medical fees of the GMHI, each insurer in the AMHI determined its own fee schedule and benefits. Consequently, although the Health Insurance Law was established as the first national health insurance for industrial workers, the establishment itself did not automatically grant the government great authority to intervene in health insurance. It was only when World War II came in sight that the government moved to do so.

CHAPTER TWO

Catching Up with Europe

The United States before 1941

Through the first half of the nineteenth century, the United States lagged behind major European countries, such as Britain and France, in degree of industrialization. By the late nineteenth century, however, the United States had become an important economic power in the world. As the country became more industrialized, the United States faced unprecedented social problems. Urban workers worked in poor sanitary conditions; moreover, many of them lost their jobs in the economic downturns. In response to the new social conditions, in the early twentieth century the reform-minded federal bureaucrats and intellectuals sought to expand social programs by borrowing from European models. Health insurance was one of the important policy fields in which they emulated the Europeans. Their efforts, however, did not result in a rapid expansion of health insurance. The power of the American Medical Association (AMA) was an important factor in limiting its spread.

THE DEVELOPMENT OF THE AMERICAN MEDICAL ASSOCIATION

As in Japan, the mobilization of medical interests in the United States concerned the professionalization of medicine. Around the founding period of the United States, medical practice relied more on the doctors' own experiences than on scientific research. The nineteenth century, however, saw the rise of a movement to make medicine more scientific and professionalized. The move-

ment called for the standardization of medical education, the introduction of licensing, and the establishment of medical associations in order to promote the scientific way of practicing medicine. It was the American Medical Association (AMA) that led the way. By the 1920s, the AMA had achieved these goals and had became a politically strong interest group in American medicine.

Avoiding Too Much Competition

In the nineteenth century, medicine in the United States was less professionalized than in Europe. The clergy often conducted both religious and medical services for their congregations. Men and women in lower social ranks also often practiced medical services without sufficient formal medical education. Medicine was not a profitable profession for two reasons: the population was spread out over large areas of land and few people were wealthy enough to afford sufficient medical care. Under these circumstances, doctors were reluctant to make long trips to patients, and many family members had no option but to care for the sick themselves.[1]

Industrialization, which started in the mid-nineteenth century, partly solved this problem by producing a middle class that was concentrated in urban areas and could spend money on medical matters. The transportation revolution initiated by industrialization also made it easier for doctors to visit patients or vice versa, even in areas where the population was scattered.[2] Industrialization, however, was not a cure-all. In urban areas where doctors could see many patients within a short distance, a second problem occurred: there were too many doctors. To complicate matters, physicians formally trained in scientific medicine competed with a wide variety of "unscientific" practitioners, such as botanic practitioners, midwives, cancer doctors, bonesetters, and inoculators. They also faced competition with other medical sects practicing Thomsonianism or homeopathy. As a result, not many doctors pursued a formal medical education because the personal investment in education often did not bring a sufficient financial reward.[3]

By the turn of the century, however, more and more doctors were earning medical degrees. By the 1920s, then, the number of doctors without a medical degree was greatly reduced. A survey of nine thousand families showed that, from 1928 to 1931, only 5.1% were cared for by non-MD practitioners.[4] Leaders of the AMA who sought to make medicine more scientific and professionalized contributed to this drastic change.

The Rise of the American Medical Association

Before the mid-nineteenth century, medical education was clearly inadequate. Applicants without high school diplomas were often accepted. The medical schools themselves lacked a systematic curriculum. American medicine was full of "quacks and charlatans," as Odin W. Anderson put it.[5] Paul Starr noted that "medicine epitomized both the backward state of higher education and the degraded state of the professions in America."[6]

Some doctors began to form medical associations to overcome this uneasy condition of American medicine. In the mid-eighteenth century, regional medical associations emerged in Boston and New York and spread to other areas.[7] In 1845 Nathan Smith Davis of the New York Medical Association introduced a resolution to coordinate regional medical associations and create a national association. Although some considered his proposal "impractical, if not utopian," the resolution led to the creation of the AMA in 1847, and Davis became known as a founder of the AMA.[8]

Medical education was one of the top priorities of the new organization, which promulgated the mission of a shared medical ethics and advances in medical science.[9] Davis carried out the spirit of the AMA for improving medical education when he established the Medical Department of Lind University in 1859, which became the Chicago Medical College in 1862 and the Northwestern Medical School in 1892. Davis demanded that the length of training be extended to three years and that the bar of entry for students be raised: they had to be college graduates or pass an examination.[10]

Davis passed the torch of medical school reform to Charles Eliot of Harvard University and Daniel Coit Gilman of Johns Hopkins University. When Eliot, a chemist, assumed the presidency of Harvard in 1869, he reorganized its medical school. Before that, didactic lectures were the core of the program, and students could graduate by passing only a majority of their examinations. Because of Eliot's reforms, however, students were required to pursue laboratory work and pass all the examinations.[11]

Daniel Coit Gilman, a geographer and the first president of the Johns Hopkins University, played an important role in founding and modernizing its medical school. The medical school offered an unprecedented four-year program and required all entering students to have college degrees. Unlike the conventional programs, furthermore, faculty members were drawn from outside Baltimore based on their research ability. Gilman's reforms made medical education longer, more prestigious, and more research-oriented. Paul Starr

has described Gilman's reform as "the most radical departure from the old regime."[12]

Meanwhile, the AMA institutionalized mechanisms to promote medical research and education. The *Journal of the American Medical Association* (*JAMA*) began publication in 1883 with its first editor, Nathan Davis. In 1901, *JAMA* published its first annual Medical Education Issue, and in 1904, the AMA set medical education as a top priority and established the Council on Medical Education. The Council on Medical Education had a permanent secretary and five medical professors from major universities and made proposals to improve medical schools. It prevented medical schools that did not meet the AMA's minimum requirements from having their students' degrees recognized in the state board exam.[13] Martin Kaufman has indicated that reform-minded doctors were greatly influenced by Europe. Many of them had pursued postdoctoral work in Germany, which was "the medical capital of the world in the late nineteenth century."[14]

As the AMA promoted the professionalization of medicine and controlled competition among doctors, more doctors became AMA members. The AMA's membership rose from about 7% of physicians in 1901 to more than 50% in 1915 and to 65% in 1930.[15] With a short disruption during the Great Depression, by 1940 the proportion had reached its highest level, about 67%. Participation in the AMA was motivated by a "career imperative as well as a shared professional culture," while "defying the medical societies became 'professional suicide.'"[16] As the AMA increased its membership, the AMA gained financial power. But in order to influence the policy process, it relied both on the money and on doctors' prestige in the society and their influence on the political opinion of their patients. As the *Yale Journal of Law* has written, "The potential strength of the AMA is to a large degree attributable to the status of the doctor in society. Because of his services to humanity, his learning, and economic position, the physician enjoys prestige and public confidence."[17] While the AMA strengthened its political power, however, it faced a new challenge: the rise of health insurance.

LIMITED PROTECTION FOR THE SICK AND DISABLED

As in Japan, rapid industrialization took place in the late nineteenth century in the United States. *Progress and Poverty,* an 1879 book by Henry George, showed the deteriorating living condition of laborers in American cities. He argued that the economic development had not helped reduce poverty; rather, it had caused unprecedented economic downturns and widened the gap between

the rich and the poor.[18] His book was incredibly popular: in the 1880s, it was the bestselling book after the Bible.[19] As a result of the industrial revolution, new sources of uncertainty had been introduced into the lives of many workers. Moreover, at the same time, farmers who could not benefit much from industrial development also suffered from financial difficulties. In response to these problems, there was a movement to create both private and public health insurance at the turn of the century.

Private Measures

Commercial private insurance firms, such as Metropolitan and Prudential, started health insurance divisions in the late nineteenth century. They first provided workers with a flat daily compensation for missed days due to illness or injury—typically two-thirds of the wage.[20] However, the commercial firms did not go beyond the idea of "welfare" payment, giving minimum cash to workers.[21] It was only in the 1930s that private health insurance firms gradually expanded plans to include hospitalization and surgical costs.

There were other mechanisms that threatened the financial basis of individual practitioners. In the early twentieth century, many companies adopted a "contract practice," in which doctors were hired on a salary basis to furnish medical care to their workers. It was part of the employers' efforts to build up their employees' loyalty by offering various welfare services.[22] Individual practitioners were worried about contract medicine because it eliminated the autonomy of hired doctors to set fees, and, more importantly, it took patients from them. "The dislike of physicians for 'socialized medicine' is well known," Paul Starr wrote, "but their distaste for corporate capitalism in medical practice was equally strong."[23]

In 1908, for example, the Chicago Medical Association ousted a doctor who worked at Sears Roebuck as a contract physician because it considered his discount service to the employees' families "an unethical invasion of private practice."[24] In 1930, the Judicial Council of the American Medical Association noted that "it is the opinion of the Judicial Council, based on present evidence, that such practice [contract medicine] is detrimental to the best interests of scientific medicine and of the people themselves."[25] Because contract medicine would provide treatment only by designated physicians in designated hospitals, the AMA, which relied on individual practitioners for its membership, tried to block the spread of the practice.

Group practice, which emerged in the late nineteenth century, was another challenge to traditional individual practitioners. The Mayo Clinic, the first group practice, started when William and Charles Mayo and their father opened a general practice in the 1880s. They expanded the clinic by hiring physicians, including various specialists, dentists, laboratory technicians, nurses, and other workers. To individual practitioners, group practice challenged the traditional relationship between doctors and patients by restricting the patients' freedom to choose their doctors. Moreover, individual practitioners often complained that group practice undersold care. In 1922, the AMA declared its opposition to any type of group practice by calling such groups "unprofessional."[26] Although the Mayo Clinic became a large organization, hiring 386 physicians and dentists by 1929, and admirers of the Mayo Clinic opened similar clinics across the country, group practice was limited to small cities, and its growth slowed down as the number of specialists increased and hospital facilities developed.[27]

Prepaid plans evolved as extensions of group practice and employer-provided medical services. In 1929, Donald Ross and G. Clifford Loos had a contract with employees of the Los Angeles Department of Water and Power to provide both hospital care and medical care for a two-dollar monthly premium per subscriber. By 1935 enrollment had increased to more than 12,000 workers and 25,000 dependents. Such programs spread across the country. The establishment of these plans, according to Paul Starr, was not based on a particular ideology but was a pragmatic response to workers' health problems. But it was "a more significant change in the structure of medical services than they [contracted doctors] understood."[28]

When the idea of prepaid plans was connected with the cooperative movement, which had originated in England, the AMA realized that it had to make a serious effort to fight against the private prepaid plans. In Elk City, Oklahoma, in 1929, Michael Shadid, an immigrant from the region today known as Lebanon, formed the first medical cooperative. The medical cooperatives were based on four principles: group practice, prepayment, preventive medicine, and consumer participation. Because many individual practitioners were reluctant to accept these principles, Shadid faced furious opposition from the state-level medical society. The local medical association pursued a long campaign to crush Shadid's efforts through its influence on licensing requirements and malpractice insurance.[29] Despite the opposition that medical cooperatives faced from local medical associations, they spread to other areas.

The AMA's fight to block the expansion of a medical cooperative in Washington, D.C., went to the U.S. Supreme Court. In 1938, the AMA was indicted for violating the Sherman Antitrust Act because of its efforts to take down the Group Health Association. The GHA was established in 1937 as a nonprofit cooperative that provided hospital and medical care to employees of the Federal Home Loan Bank through salaried physicians. The AMA argued that antitrust laws did not apply to medicine because medicine is not a trade but a profession. In *American Medical Association v. United States* (1943), the Supreme Court confirmed the AMA's antitrust violation.[30] The AMA's defeat in the court case, however, was "little more than a moral victory for the supporters of the cooperatives," and organized medicine continued to carry out reprisals against doctors who joined prepaid group practice.[31]

Although organized medicine initially was hostile to private prepaid plans, an innovation in private health insurance in the 1920s had the potential to change the perception of doctors toward private plans. The innovation came first in the field of hospital insurance; health care providers themselves got directly involved in running health insurance plans. Some hospital entrepreneurs created organizations to provide hospital insurance in the face of the financial difficulties of their hospitals. In 1929, Baylor University Hospital in Texas started to provide schoolteachers with up to twenty-one days of hospital care a year for six dollars per person.[32] This hospital insurance would later become Blue Cross. Blue Cross spread to other areas because it targeted employee groups almost entirely and avoided the adverse selection problem that the commercial health insurance companies had suffered—sick people are more likely to participate in insurance.[33] Moreover, the leaders of Blue Cross plans pushed state governments to pass legislation that gave them nonprofit status and favorable tax treatment.[34]

Although the American Hospital Association was initially skeptical about the Blue Cross plans, their attitude soon changed.[35] In 1933, the AHA declared that Blue Cross plans were "a form of social insurance under nongovernmental auspices, not merely a form of private insurance under non-profit auspice," and it took a leadership role in expanding Blue Cross plans.[36] As long as Blue Cross dealt exclusively with hospitalization costs, not medical-surgical fees, the AMA did not express a strong objection to Blue Cross plans.[37] The program expanded to many states with seed money from foundations, such as the Julius Rosenwald Fund, a Chicago-based philanthropy founded by a partner in Sears Roebuck.[38] By the end of 1936, twenty-one Blue Cross plans were established, and thirty-nine Blue Cross plans were covering about six million people by 1940.[39]

The spread of Blue Cross inspired some "maverick physicians" to create health insurance plans for medical-surgical expenses, later called Blue Shield.[40] In the late 1930s, Blue Shield was established as the "junior partner" of Blue Cross.[41] Some of the Blue Shield plans gave only cash indemnities. Moreover, even plans offering service benefits often targeted only low-income subscribers and covered doctors' services in hospitals.[42]

Although state- or county-level medical associations were cautious about the emerging new health insurance plans, they soon realized that they could no longer keep ignoring health insurance and began to look into how they could live with it. As early as 1932, for example, the Michigan State Medical Society began its study of health insurance. In 1939, the California, Michigan, and Pennsylvania medical societies established plans that targeted statewide residents.[43]

Offering prepaid health insurance plans themselves, some local medical societies sought to make sure that they retained sufficient influence over their plans. In 1939, they began to pressure state governments to assure that doctors would control all prepayment plans and that patients would have free choice of doctors. By the end of the 1940s, twenty-six states passed laws to ban consumer-run medical services, such as medical cooperatives. Of these, seventeen states also prohibited medical services from restricting patients' freedom to choose doctors.[44]

Although state- and county-level medical societies introduced Blue Shield plans, the AMA was still skeptical about the development of that kind of private health insurance. Their most critical concern was that Blue Shield plans set their own uniform fees, which deprived doctors of the freedom to decide fees on their own. The AMA could not endure this because of its original motive of blocking any intervention between doctors and patients and maintaining the traditional fee-for-service practice.[45] The AMA House of Delegates stated in 1938 that "in any plan or arrangement for provision of medical services the benefits shall be paid in cash directly to the individual member. Thus, the direct control of medical services may be avoided."[46] What the AMA could accept was indemnity only, which provided a certain amount of cash to patients no matter what medical incidents they had.

In sum, the development of private measures that challenged the traditional way of practicing medicine took various forms in the late nineteenth and early twentieth centuries: commercial insurance companies, firm-based contract practice, group practice, and medical cooperatives with a prepayment mechanism. Finally, private health insurance plans, in the form of Blue Cross and Blue

Shield, emerged. The AMA maintained its opposition to any plans that challenged doctors' autonomy to set fees. While the AMA fought against private health insurance, it also opposed the government's proposal for public health insurance for workers. The next section describes what public health insurance was proposed, what plans developed, and how the AMA campaigned against the further development of public health insurance.

Public Measures

As private health insurance, albeit in a limited form, developed in the United States, some government officials, doctors, and scholars began to push for the introduction of public health insurance programs. According to Monte Poen, Michael Davis and Isidore Falk were two important "institutionalists" who were "involved in the scientific and technological advance of medicine."[47] They supported the government's involvement in health care financing to secure the people's access to care. They often had conflicts with the AMA, which gave more priority to doctors' autonomy from government authority. Talcott Parsons has described this conflict "an internal polarization of the medical profession between a numerical minority who were the leaders in the technical advancement of the profession and its services to the general community and a majority who have in general participated less in these trends."[48]

Reformers like Davis and Falk began their fight against organized medicine with public programs that had been established in the United States. The U.S. Marine Hospital Service was the federal government's first attempt to be involved in health care. In 1798, President John Adams established it by signing a bill to create a compulsory health insurance program for merchant seamen; sick or disabled seamen received care in the assigned hospitals. The Marine Hospital Service was created "to deal with a group that was commercially and epidemiologically strategic because of its role in foreign commerce," as seamen were "the Nation's economic lifeline and a major element of its naval defense."[49] The Marine Hospital Service continued to exist through the nineteenth century, offering more favorable terms to seamen. In 1884, Congress passed legislation to exempt the seamen's premium payments to the Marine Hospital Service. A special tonnage tax and general revenues covered the expenses of the hospital system. The tonnage tax was eliminated in 1905, and thereafter general revenues supported the Marine Hospital Service.[50] In 1912, the Marine Hospital Service was incorporated into the U.S. Public Health Service (PHS), which at that time was located in the Department of Treasury. In addition to providing

health insurance for seamen, the Marine Hospital also functioned as a public health measure to defend against epidemic diseases from abroad. The Marine Hospital Service, according to Odin Anderson, "marked the first time that federal, state, or local governments dealt with special groups and problems rather than general health programs."[51]

War veterans were also beneficiaries of public health care programs. In 1776, the Continental Congress first passed legislation offering pensions for disabled veterans.[52] In February 1811, Congress enacted a law to authorize the construction of a permanent home for disabled naval officers, seamen, and marines. After the Civil War, the federal government used federal revenues to provide Union veterans with pensions for those with service-related disabilities and homes for the disabled. The benefits depended on the severity of the disabilities. For example, the federal government paid 1,200 dollars a year for total loss of sight and 360 dollars for the loss of a hand. In October 1898, furthermore, hospital care near their homes was first authorized for veterans.[53]

The federal government took a more earnest step to provide medical and hospital services to veterans after World War I. In 1921, the Veterans Bureau was established to coordinate the payments and services for veterans: the Rehabilitation Division of the Federal Board of Vocational Education, the Bureau of the War Risk Insurance, veterans' hospitals, and PHS-run hospitals underwent administrative integration. Furthermore, in 1930 the Veterans Administration (VA) was established to consolidate the Bureau of Pensions, the National Home for Disabled Volunteer Soldiers, and the Veterans Bureau.[54]

In 1922, Congress passed a law to provide hospital care not only to World War I veterans but also to the veterans of the Spanish-American War, the Philippine Insurrection, and the Boxer Rebellion. Medical care was also offered to World War I veterans with non-service-connected disabilities, such as neuropsychiatric disabilities or tuberculosis. Between 1925 and 1941, 73.6% of the VA hospital cases were non-service-connected.[55] The federal government initially offered medical and hospital care mostly at private facilities by contract, but it also began to expand the public VA hospital system. By World War II, the VA hospital system included ninety-one hospitals, which provided hospital and domiciliary care for nearly eighty thousand veterans, and it became the largest hospital network in the United States.[56]

Odin Anderson has noted that these institutional and policy developments in veterans' health care took place in part thanks to the government's experiences with the Marine Hospital Service. He argued that the Marine Hospital Service "may have set a precedent for financing the medical care of veterans

after World War I, since their care was paid for completely from general revenues."[57] The PHS, which took over health care for seamen from the Marine Hospital Service, indeed administered health care for veterans.[58]

As the federal government dealt with veterans' care in the 1920s, it was also beginning to provide health care to other groups: mothers and infants. In 1912, the Children's Bureau was established within the Department of Commerce and Labor. The Children's Bureau played a role in collecting data for improving the condition of child labor and the health of mothers with infants. However, the Children's Bureau began to play a different role when the Sheppard-Towner Infancy and Maternity Protection Act was passed in 1921. The Sheppard-Towner Act, "taking advantage of the new power of the female franchise," allowed the Children's Bureau to extend its role to providing matching funds to states for prenatal hygiene and infant care to reduce rates of maternal and infant mortality.[59] The Children's Bureau supervised the states' programs.[60] The Sheppard-Towner Act was "outside the mainstream of official public health," according to Anderson, and the new public program had "the greatest potential effect on the private practice of medicine and curative medicine."[61]

The Sheppard-Towner Act stated that the federal government was responsible for providing care for women and children. Under the provisions of this act, an increasing number of nurses were publicly employed to serve in health centers.[62] Because this program had the potential to cover all women and infants, moreover, Julia Lathrop, the first director of the Children's Bureau, asserted that this program was "designed to emphasize public responsibility for the protection of life just as already through our public schools we recognized public responsibility in the education of children."[63]

While the federal government was providing care for veterans and mothers/infants in the 1910s and 1920s, reformers were also calling for a public health insurance program for workers. By the 1920s it was widely known that many workers could not or rarely did see doctors because of financial difficulties. Many workers made a living at low wages and did not have a sufficient safety net for sudden accidents or illnesses. Moreover, technological development in medicine had boosted the cost of medical treatment. To make medicine more accessible for workers, reformers sought to create a public health insurance program for workers.

Before public health insurance, in the 1910s many states passed worker compensation laws. Worker compensation originally took the form of cash payments to make up the wage loss of workers who had gone on leave because of disabilities and diseases associated with their occupation. But it began to

provide those workers with the cost of medical care, and it also set reimbursement methods and designated doctors and hospitals they could go to. Thus, as Odin Anderson noted, "worker compensation may be regarded as the first general government-sponsored program to involve hospitals and physicians; it went beyond government's traditional concern for the indigent, the mentally ill, and groups under its auspices, such as seamen and servicemen."[64] With court decisions between 1910 and 1916 legalizing insurance schemes sponsored by state governments, by 1920 forty-two states had passed worker compensation laws.[65] In the implementation of these laws, the government officials could collect statistics about the health of workers, advance the technique of calculating health insurance costs, and prepare policy proposals in health insurance for workers' non-occupation-related disabilities.

The movement to create a public health insurance program for workers came to light when Theodore Roosevelt claimed "the protection of home life against the hazards of sickness" in the platform of the Progressive Party.[66] He believed that "no country could be strong whose people were sick and poor."[67] However, Roosevelt did not win the presidential election in 1912, and the new president, Woodrow Wilson, did not pursue Roosevelt's dream.

Then the American Association for Labor Legislation (AALL) took over the task. The AALL was founded as a group of "'social progressives' who sought to reform capitalism rather than abolish it" and prepared proposals for social security measures.[68] In 1915, the AALL drafted a proposal for compulsory health insurance modeled on German legislation. The AALL plan held that employers and employees would get involved in administrating the program under public supervision and that private insurance carriers could be included.[69] Some important officers in the United States Public Health Service supported the AALL proposal, including Edgar Sydenstricker, who advocated the expansion of government authority in health care in the United States Public Health Service until 1936, when he died suddenly of a cerebral hemorrhage. He and other reform-minded officials believed that "a compulsory insurance scheme would require financial contributions from industry, workers, and the community" and that "it would encourage them to support public health measures in order to prevent disease and save money."[70]

The AMA did not initially regard the AALL plan as a serious threat. It was flexible in terms of the provisions that would affect physicians, such as fee schedules and patients' freedom to choose their doctors. To the AALL's "pleasant surprise," the AMA showed a supportive attitude toward the AALL plan. In 1915, *JAMA* discussed the AALL proposal, claiming, "It is hoped physicians

would take advantage of this opportunity and that it would be possible to avoid the lack of cooperation between physicians and legislators which, for a time, marred some of the foreign legislation."[71] At the annual meeting of 1915, the Judicial Council of the AMA, led by Alexander Lambert, personal physician to Theodore Roosevelt and himself later president of the AMA, also submitted a report supporting social insurance schemes. George H. Simmons, editor of *JAMA,* was also among the AMA leaders who supported the AALL plan. The AMA cooperated with the AALL to set up a three-man committee in order to revise the details of the AALL proposal. This body, called the Committee on Social Insurance, was located in the same building as the AALL in New York. In 1916, with the AMA's approval, Lambert was appointed the committee's chairman, and Isaac M. Rubinow, a socialist, was hired as its executive secretary.[72]

Although a united front for public health insurance for workers seemed strong in 1916, the coalition fell apart soon afterward. Right after the United States entered World War I in April 1917, the AMA closed down its committee on social insurance, which had submitted the final report to the AMA's House of Delegates for supporting health insurance. World War I influenced the discussion of public health insurance in its economical and ideological aspects. Paul Starr has pointed out that because the wartime economy boosted the income of physicians, public health insurance became less attractive to the AMA as a means of boosting doctors' income.[73] James Morone has also noted that the war caused an ideological dimension to public health insurance. The House of Delegates mentioned in 1918 that compulsory public health insurance was a "dangerous device . . . announced by the German emperor from the throne the same year he started plotting to conquer the world."[74] Thus, although the AMA was almost ready to agree to some kind of public health insurance proposal in the mid-1910s, the AMA in 1920 officially announced their opposition "to the institution of any plan embodying the system of compulsory contribution insurance against illness."[75]

The AMA's decision to disapprove of public health insurance for workers led it to fight against the public measure to offer medical care for mothers and infants. After the program was implemented, the AMA tried to abolish it. One of the AMA's concerns was that the program's preventive care for mother and infants would weaken the financial power of individual practitioners because curative care occupied a large portion of their income.[76] The AMA condemned the Infancy and Maternity Protection Act as an "imported socialistic scheme" of "state medicine."[77] The AMA succeeded in getting Congress to discontinue the program in 1929.[78]

The AMA also took action against the government's health care program for veterans. In their annual meeting in 1928, the AMA warned that the VA health care would lead to the nationalization of medicine. The AMA's Bureau of Legal Medicine and Legislation called the attention of the House of Delegates to the federal government's attempt to bring about the "socialization of medicine through the expansion of the care given to veterans."[79] In the meeting in 1930, furthermore, the House of Delegates adopted resolutions against federal aid for medical care to veterans regardless of the origin of their disabilities.[80]

The 1920s started with a political sentiment of return to normalcy, which gave reformers no chance to introduce public health insurance. But the Great Depression, which was triggered by the sharp drop of the New York stock market in 1929, provided an opportunity for Franklin Roosevelt to introduce new social policies. In 1934, Roosevelt set up the Committee on Economic Security, which Secretary of Labor Frances Perkins led as chairperson, in order to study social security programs. Its subcommittee on medical care included health insurance specialists who had fought to introduce compulsory health insurance in the previous few decades. In particular, Edgar Sydenstricker, one of the leaders in creating the AALL plan, directed a technical study about health insurance.[81] The reformers tried to introduce compulsory health insurance in the Social Security Act of 1935 along with other social security programs, such as unemployment insurance and old-age pensions. But the AMA's opposition led Roosevelt to conclude that if he had included health insurance in the bill, the "political dynamite" would have destroyed the prospects of the entire bill.[82]

Although Roosevelt did not openly support public health insurance, he promoted institutional development for planning public health insurance. After the passage of the Social Security Act of 1935, Roosevelt appointed an Interdepartmental Committee to Coordinate Health and Welfare Activities, which mandated assistant cabinet secretaries to observe whether the provisions in the Social Security Act were being administered properly and to solicit further suggestions in social policy. The Technical Committee on Medical Care was established within the Interdepartmental Committee for reviewing the health service provisions and making recommendations for future government proposals in health insurance.[83] The Social Security Board, which was created to administer most of the programs in the Social Security Act of 1935, became the leader in the preparation of future public health insurance legislation. Social Security Board Chairman Arthur Altmeyer, along with his prominent adviser on health insurance, Isidore Falk, became leaders in this task.[84]

The Technical Committee called the National Health Conference in Washington, D.C., in July 1938 in order to make a recommendation for national health insurance. For the first time, this kind of conference officially brought labor into the discussion of national health insurance.[85] The recommendations by the National Health Conference led directly to the National Health Bill introduced by Senator Robert Wagner (D-New York) in 1939. The National Health Bill suggested that the federal government give grants to the states for their health care policy. The state government used the grants to expand public health measures, build public health facilities, and promote public health insurance. The National Health Bill was moderate in the sense that it gave no authority to the federal government to require the state governments to set up specific programs. As Alan Derickson concluded, "The National Health Bill had little potential to expand American's access to medical care to any substantial extent."[86]

Interdepartmental coordination was enhanced by the creation of the Federal Security Agency in 1939 for promoting New Deal social welfare programs.[87] The Social Security Board, previously an independent agency, was moved to the FSA, and the U.S. Public Health Service was transferred there from the Treasury Department.[88] Within the FSA, the SSB and the PHS were the main agencies pressing for the government's intervention to improve the health of Americans.

The AMA reacted to the federal government's aspirations for future health insurance legislation with furious opposition. After discovering that the Social Security bill called for the SSB to study issues concerning health insurance, the AMA in February 1935 called a special meeting of the House of Delegates for only the second time in the AMA's history. In the meeting the AMA reaffirmed its position opposing any government intervention in health insurance. The AMA also played a major role in blocking Wagner's 1939 bill.[89]

While the AMA blocked the creation of a national health insurance for workers in the 1930s, the federal government achieved some success in encouraging health insurance plans for rural areas. In 1935, the federal government began to subsidize medical cooperatives in rural areas. The Resettlement Administration set up a program to subsidize cooperative medical prepayment plans for low-income farmers. Under this program, the federal government typically engaged in negotiating with local medical associations to set a limit on their fees.[90] The Farm Security Administration in the Department of Agriculture took over the program in 1937.[91] Frederick Mott and Milton Roemer, career physicians in the PHS, played a large role in the farmers' health insurance plans, believing that farmers' poor health resulted in poor agricultural productivity. In addition, fewer doctors were practicing in rural areas because they preferred

to be in urban areas, with their larger populations and higher fees.[92] Paul Starr wrote, "In effect, this was government-sponsored health insurance. Barely noticed in political debate, the plans covered a quarter of the population of the Dakotas."[93] Although the medical cooperatives became large in some rural areas, the coverage was limited nationwide: by June 1941, this program's membership numbered 682,000, but it included only 0.5% of the population.[94]

In sum, the federal government began to take responsibility to provide care for seamen and veterans as early as in the late eighteenth century and subsequently developed its capacity by creating programs for mothers, children, and farmers. The creation of state-level worker compensation laws also encouraged reformers to push for national health insurance for workers. But the AMA succeeded in blocking the federal government's proposals for further expansion of national health insurance. As a result, before the 1940s, the federal government got involved in providing care for veterans, mothers, and farmers, but many Americans were left beyond the reach of national health insurance. More comprehensive government intervention in health insurance would have to wait until World War II.

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PART TWO

Health Security as National Security

This second part of the book shows that World War II (1937 to 1945 for Japan and 1941 to 1945 for the United States) led to the expansion of health insurance in both countries. It also explains what made the two countries adopt different health insurance policies by the end of the war. It argues that war mobilization changed the politics of health insurance because health insurance was enmeshed in national defense matters and that the adaptation of the different health insurance systems is related to each nation's different war experience.

Richard Titmuss demonstrated fifty years ago that the experience of total war led the British government to treat social policy as a national security issue.[1] Part II demonstrates that the governments in Japan and the United States also saw health insurance as a tool to make the people physically and mentally strong. The government's action to expand health insurance played a role in strengthening people's bodies and boosting national morale. For the government, therefore, health insurance became part of national defense. World War II also gave the governments of Japan and the United States more power to produce social policy while it diminished the power of the Japan Medical Association (JMA) and the American Medical Association (AMA), respectively. In the face of a national crisis, the government could better justify its involvement in the economy and society. On the other side, the war also forced the national medical associations and individual doctors to cooperate with the government's war activities. As a result, total war decreased the power of the medical associations to oppose the government's interventions in health insurance.

Although World War II promoted health insurance in Japan and the United States, Japan's war experience and America's war experience were not identical, and the differences between the two war experiences affected the development of health insurance in each country. The differences include the duration and depth of mobilization and the sequence of the war. To see how the duration and depth of mobilization influenced health insurance, one must distinguish between the government's projections of the duration and depth of mobilization and the actual course of the war. The government's projections about how long and deep the war mobilization would be shaped its policy preference. Table P2.1 shows four possibilities, based on two scales—projected duration and projected depth of mobilization: (1) certain and steady; (2) uncertain and steady; (3) certain and rapid; and (4) uncertain and rapid. Whether mobilization is considered steady or rapid depends on whether the demands for the armed forces and the war economy could be met with or without a drastic mobilization policy. Additionally, whereas a certain-duration war means the government projects that the war will soon be over, uncertain-duration is a situation in which the government cannot project how long the war will last.

First, when the government projects certain/steady mobilization, it prefers to maintain the existing health insurance policy. The government has no interest in reforming health insurance in that instance because it knows that manpower for war activities can be and will be met with existing human resources. The government also seeks to establish a source of revenue for more direct war activities such as producing cannons, tanks, and ships. Japan experienced this type of projection from July 1937 to December 1937, when the government projected that the war with China would end soon. The United States experienced it from May 1945, when the United States began demobilization after Germany's surrender, to August 1945, when the war ended with Japan's surrender.

Second, when the government projects uncertain/rapid mobilization, it favors radical reform in health insurance, in both quality and quantity. In order to prepare a deep mobilization without knowing when the war will end, the government deals more directly and thoroughly with the health and morale of the population. During uncertain/rapid mobilization, more people are drafted; the war industry requires additional workers; workers become a reservoir for future soldiers; the unemployed, women, and minorities are urged to make up for the shortage of workers; and mothers and children become important for producing the next generation of soldiers. To respond to such a situation, the government needs top-down measures to improve the health and morale of the entire population. Japan experienced this period from July 1940, when it decisively expanded its war front

from China to other Asian regions, to August 1945. The American government projected uncertain/rapid mobilization from May 1941, when it declared an unlimited national emergency, to December 1943, when the victory of the Allied Powers became clear.

Uncertain/steady mobilization and certain/rapid mobilization are intermediate cases in which the government prefers to make moderate reforms: moderate reform includes both incremental and patchwork efforts by the government. In an uncertain/steady mobilization, the government faces a dilemma: although manpower for war activities can be met relatively easily, the uncertainty about when the war will end means that the government also needs to prepare for an uncertain/rapid mobilization that may happen in the future. As a result, the government favors less politically controversial reforms, such as the gradual expansion of existing programs and the promotion of voluntary programs. Japan experienced a period of uncertain/steady mobilization from 1938 to mid-1940, when the battle front was limited to China. For the United States, this period lasted from 1944, when war mobilization stopped increasing, to April 1945.

Finally, in a certain/rapid mobilization, which neither Japan nor the United States experienced, the government faces a different dilemma: although the government needs to mobilize a large portion of the population quickly, it simply does not have the time or institutional resources to implement radical reform. Therefore, the government produces emergent, and politically easy, measures for selected groups, such as military personnel, their families, and workers in war industries, who play a more direct part in the war than the rest of the population. Table P2.1 shows how the government's war projection and policy preferences changed.

What the government wishes to do is different from what the government can actually do. While the government's projections about the war shapes its health insurance policy preferences, three other war-related factors influence the government's ability to turn its policy preference for radical reform into

TABLE P2.1.
The course of the state's war planning and its policy preference

Japan	Certain/Steady Jul. 1937–Dec. 1937	→	Uncertain/Steady Jan. 1938–Jun. 1940	→	Uncertain/Rapid Jul. 1940–Aug. 1945
United States	Certain/Steady May 1945–Aug. 1945	←	Uncertain/Steady Jan. 1944–Apr. 1945	←	Uncertain/Rapid May 1941–Dec. 1943
State's policy preference	Non-intervention		Moderate reform		Radical reform

actual policy outcomes: the actual length of the war, the depth of mobilization, and the sequence of the war. First, the longer and deeper the war, the more power the government possesses and the less power medical associations possess. In a longer and deeper war, which becomes a life-or-death question for the nation, the government is given more authority to make policy changes for the nation's survival, whatever the costs; the medical associations become enmeshed in the government's war activities and individual doctors are taken to the field. As a consequence, the longer deep mobilization lasts, the more likely it is that radical reform will take place. Although the highest mobilization rate was not much different in Japan and the United States, the length of the war differed: the Japanese war lasted ninety-seven months, while the American war lasted fifty-six months.

Second, the sequence of the war, more concretely when the major increase of mobilization occurs, also affects whether the government can pursue radical reform. As Paul Pierson noted, "when a particular event in a sequence occurs will make a big difference."[2] Because an abrupt rise of mobilization took place in Japan late in the war, the government was able to take advantage of the preceding steady mobilization period to coordinate with medical associations and integrate government agencies. In contrast, because in the United States the radical increase happened in the early period of the war, the government was more busily immersed in emergent measures, such as arraying troops and making diplomatic efforts. Quite simply, in the former case, the government was less pressed for time to make radical reform happen.

Before closing this introduction to Part II, it should be repeated that World War II alone did not create a certain health insurance policy in a political vacuum, whether in Japan or the United States. The formal political structure, interest group politics, political culture, and preexisting policies also influenced the development of health insurance policy. Nevertheless, we must take the impact of World War II into account and recognize that health insurance became part of national defense in both countries, all the while remembering that Japan's war experience was different from that of the United States. During the war, health security for people became national security in Japan and the United States, but as national security policy differed in the two countries, so too were health security policies different.

CHAPTER THREE

Creating a Public Health Insurance System

Japan, 1937–1945

In July 1937, the Marco Polo Bridge Incident opened the battle between Japan and China. Subsequently, by its attack on Pearl Harbor in December 1941, Japan started a war against the Allied Powers. In Japan, the periods before and after Pearl Harbor have often been considered separately; the former is often called the (Second) Sino-Japanese War, and the latter is called the Pacific War. While this book sees the difference between these two phases in terms of the degree of war mobilization, it recognizes the continuity of these two wars and calls them together World War II.

Some scholars also argue that not the Sino-Japanese War but rather the Manchurian Incident of 1931 was the beginning of Japan's World War II. After this event, the Japanese military invaded Manchuria, the northeastern part of China, and established a puppet government. Scholars who take this view call the series of the wars that eventually ended in 1945 the "fifteen-year war."[1] They assume that although the Tanngu Truce of May 1933 resolved the Manchurian Incident, Japan did not end its aggressiveness and combat readiness. Although this book does not completely disagree with the viewpoint that there was continuity before and after the Marco Polo Bridge Incident in terms of the government's war preparation, this book takes the position that it was not until the Marco Polo Bridge Incident that the Japanese government took seriously the possibility of a full-scale war against China. This chapter begins to demonstrate how the Marco Polo Bridge Incident opened a window of opportunity for health insurance legislation.

ACHIEVING MODERATE REFORM, SEPTEMBER 1937–JUNE 1940

When the Japanese government began the preparation for a future war with China in the mid-1930s, reform bureaucrats (*kakushin kanryō*) and military officers started to call for the expansion of public health insurance to improve the health of the people. Then, in 1937, the Sino-Japanese War occurred, and the government gained the ability to turn its policy preference into actual policy. Although the war with China opened a window of opportunity for the government to introduce new health insurance policies, the policies were not radical but moderate measures. That was largely because the Japanese government projected that the war with China did not require a substantial change in health insurance.

The Empowered Government in Health Care

The Manchurian Incident and the establishment of the puppet Manchukuo government isolated Japan from the international community. In 1932, in response to the Republic of China's appeal, the League of Nations dispatched the Lytton Commission, led by Victor Bulwer-Lytton, 2nd Earl of Lytton, to Manchuria. In October 1932, the Commission released the Report of the Commission of Enquiry into the Sino-Japanese Dispute, in short, the Lytton Report. Although this report admitted some of Japan's rights and legitimacy to be in Manchuria, it suggested that Manchuria should be made an autonomous region under the sovereignty of the Republic of China. Because Japan hoped to make the State of Manchukuo internationally recognized as an independent country, Japan could not accept the report. In February 1933, Minister of Foreign Affairs Matsuoka Yōsuke walked out of the assembly hall of the League of Nations after opposing a resolution condemning Japan. In March 1933, Japan made a formal announcement to withdraw from the League of Nations. In addition, Japan's withdrawal from the London Naval Treaty, which regulated naval shipbuilding, furthered Japan's international isolation and reflected its serious intention to expand its military capacity.

While Japan's international isolation continued in the mid-1930s, the government became more serious about preparing for a possible large-scale military conflict with China. Some bureaucrats and military officers began to focus more on human resource problems because the war with China would require enlisting more recruits for the military. During this war preparation period, health care and war mobilization were connected.

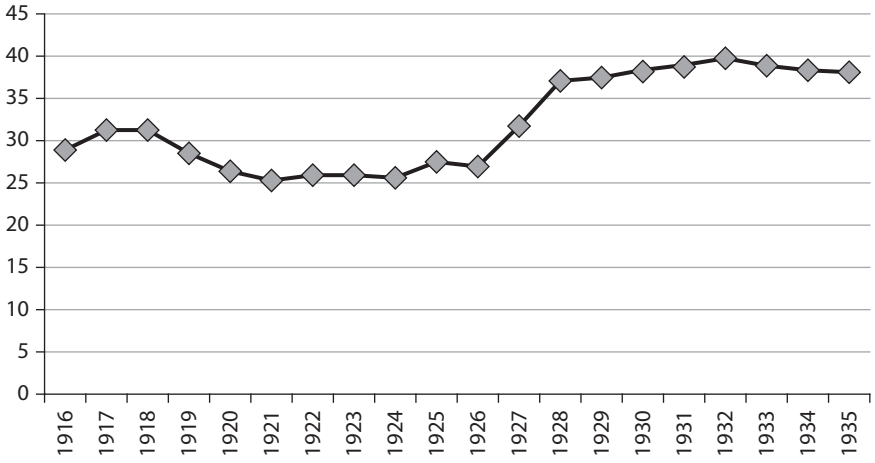

Figure 3.1. Physical Examination Rejection Rate of Japan, 1916–1935.
Source: Shō, *Nihongata Fukushi Kokka no Keisei to Jūgonen Sensō*, 44.

As an example of this connection, there emerged a movement for a new ministry for integrating health care administration and improving the health of the people. The Ministry of War was one of the first groups that advocated the creation of this new ministry. In the mid-1930s, the Ministry of War developed an interest in the health care issue, particularly after it confronted the shocking results of preliminary conscription physical examinations: more men had failed the exam than in the previous decade.[2] Figure 3.1 shows that the proportion of men who were unfit for military service remained above 35%. Moreover, an event in the mid-1930s sent an early warning to the Army, which had dispatched two divisions to Manchuria. Of these, one battalion of about five hundred soldiers had to be sent back to Japan because of tuberculosis.

Alerted by these scandals, the Ministry of War's Medical Care Bureau in June 1936 submitted an outline for a new ministry to coordinate and strengthen health care administration.[3] The Ministry of War sought to use the new ministry as "an instrument of control, especially to improve the already low physical stamina and weight of the people and to train and redistribute manpower for the purpose of insuring the supply of conscripts and laborers."[4] During a cabinet meeting in June 1936, using this outline, War Minister Terauchi Hisaichi proposed a new ministry. He explained that the deteriorating health conditions of rural youth would have a negative influence on Japan: "I have serious concerns for young men's health. The result of the physical examinations for conscription in the past three years showed that the health condition of young men

worsened and many of them failed the exam, especially because of eye problems. It has been believed that men in rural areas are healthier than ones in urban areas, but the contrary is true. This is dangerous for the nation. We must deal with this problem as an urgent national issue."[5] Terauchi also claimed that Japan should learn from European countries and establish a ministry that would deal with health care. In May 1937, the Ministry of War proposed a more detailed plan for the new ministry. It suggested that a large ministry, what they called the Ministry of Hygiene, be established to include many administration duties, including labor, transportation, insurance, and medicine. Koizumi Chikahiko, a career army officer and director of the Army's Medical Care Bureau, played a leading role in the health care issue in the Ministry of War.[6] When Konoe Fumimaro became prime minister in June 1937, Koizumi aggressively lobbied Konoe for the establishment of the new ministry.[7] During the process of Konoe's cabinet selections, the Army Minister proposed the establishment of the new ministry in exchange for supporting his cabinet. Konoe accepted his proposal.[8]

Immediately after Konoe formed his cabinet, however, the Marco Polo Bridge Incident occurred, and Japan entered the war against China. At the beginning of the war, the government was overwhelmed by foreign policy concerns. With the Ministry of War's claim that the war would not last long, the government tried to finish the war as soon as possible.[9] As a result, the government temporarily put the creation of the new ministry on the back burner. By the end of 1937, however, it became clear that the war was likely to get bogged down and that integration of health care administration would be necessary as part of the government's war mobilization efforts. In December 1937, the government consulted with the Privy Council (Sūmitsu In), which was an advisory council to the emperor, and the Privy Council approved the establishment of the new ministry. The newly established Ministry of Health and Welfare (MHW, Kōseishō) went into operation on January 11, 1938.[10]

The establishment of the MHW resulted not only from the pressure of the Ministry of War but also from the bureaucrats who were dealing with health care administration. Reform bureaucrats (*kakushin kanryō*) in the Social Affairs Bureau in the Home Ministry seeking to expand the government's authority to intervene in the economy and society played a role in pressing for the creation of the new ministry.[11] While the Ministry of War emphasized public health measures and targeted military-related personnel, reform bureaucrats put more stress on the health of ordinary people. But these two groups shared the same goal: the expansion of the government's authority in health care.

In addition to the Social Affairs Bureau in the Home Ministry, the Board of Planning (Kikaku In) pushed for the new ministry. The Board of Planning was established by the cabinet in October 1937 to coordinate war mobilization.[12] In 1938, Uemura Kōgorō, head of the Board of Planning's Industrial Division, stressed the importance of human resources in war mobilization: "Money and materials might be borrowed or found, but human resources cannot be supplemented easily, and they are at the center of the war mobilization."[13] The Board of Planning was like "the General Staff of Economy," which engaged in planning measures to strengthen the power of the government to control material and human resources, such as the National Mobilization Law (Kokka Sōdōin Hō) of 1938.[14] As a means to improve human resources, the Board of Planning also pushed for the establishment of the new ministry.

When the MHW came into operation, *Yomiuri Shimbun,* a major newspaper in Japan, marked the motivation behind the new ministry in an editorial: "It has been a long time since the idea of the Ministry of Hygiene was proposed to improve people's health. The idea has now become a reality in the establishment of the Ministry of Health and Welfare because we are facing an international crisis and need to make a concerted effort to dramatically improve people's health."[15] Okada Fumihide, secretary of the MHW from January 1939 to April 1940, stated that the MHW "was born out of the war."[16] Furthermore, Takei Gunji, undersecretary of the MHW from November 1941 to April 1944, also mentioned that the progress of the war influenced the new ministry issue: "We concluded that because the war situation was unpredictable and would last a long time we must establish the new ministry as soon as possible."[17]

The MHW consisted of five bureaus, one division, and one independent board for planning and implementing social policies. The five bureaus were: the Physical Fitness Bureau (Tairyoku Kyoku), the Public Health Bureau (Eisei Kyoku), the Disease Prevention Bureau (Yobō Kyoku), the Social Affairs Bureau (Shakai Kyoku), and the Labor Bureau (Rōdō Kyoku). In addition, the Board of Insurance (Hoken In) was established as an extra-ministerial agency.[18] The MHW also had jurisdiction over government-sponsored health care institutions, including the National Institute of Public Health (Kokuritsu Hoken Iryō Kagakuin) and the National Leprosarium (Kokuritsu Hansenbyō Ryōyōjo).[19]

During the organization process of the new ministry, the Ministry of War and the civilian reform bureaucrats came to some compromises. The former succeeded in making the Bureau of Physical Fitness the ministry's first subunit rather than the Bureau of Labor, over the preferences of the latter. Meanwhile,

the Ministry of War accepted Kido Kōichi as the first minister over its first choice, Koizumi Chikahiko.[20]

Although Koizumi was initially denied the opportunity to head the ministry, he was still considered very much its "father."[21] He presented his view of the new ministry at a conference in 1938: "Under this emergent war situation, we need to intensify the mobilization, and we must immediately improve human resources for the war. The Central Powers lost in World War I not because they lost the battles in the fields, but because their system to maintain human resources collapsed. . . . Japan also lacked such a system, but now we have the Ministry of Health and Welfare that aims at improving people's bodies for the war. . . . I would like to express my high expectation for the new ministry to aggressively advance its goal."[22] Koizumi's words clearly demonstrate that there was a close connection between the creation of the MHW and war mobilization. The Sino-Japanese War brought the Ministry of War and reform bureaucrats to reorganize and empower health care administration.

The JMA went on the defensive in the process of creating the MHW. One week after the Marco Polo Bridge Incident, the JMA sent a notification to the prefectural medical associations for "mobilizing all JMA members and contributing to the behind-the-gun activities to respond to the critical situation in northern China."[23] More specifically, the JMA demanded that the prefectural medical association get involved in relief activities, that they provide families of servicemen with medical services, and that they move to prevent and eradicate epidemic diseases.[24] Three months later, the JMA noted that "the JMA should fulfill a great mission to play a leading role in maintaining the health of the people."[25] The JMA got more involved in patriotic activities to cooperate with the government's war mobilization.

When the MHW was created in response to the war in China, the JMA expressed its disappointment. The JMA had supported the idea that the new ministry was necessary, but it was not happy about the way the new ministry was set up. In particular, it was disappointed that technical officers with medical degrees were not fully appreciated. Moreover, the JMA could not realize its hope that the new minister would be a doctor. Without a considerable number of doctors in the new ministry, the JMA wrote, "the new ministry meant nothing."[26]

As the war mobilization gradually increased, the MHW expanded its authority to intervene in the economy and society. The National Mobilization Law, passed in March 1938, provided the government with control over materials, trade, enterprises, and prices. As its supplemental law, moreover, the National Service Draft Ordinance (Kokumin Chōyō Rei) was created to empower the government

to order civilians to work in war industries. It also exercised control over employment conditions, including wage and job security. Finally, it regulated interest groups; particularly, it sought to prevent and settle labor disputes. The MHW played a leading role in implementing the National Mobilization Law. The MHW, empowered by the war, became a central actor in war mobilization policy.[27]

Moderate Reform in Health Insurance

To meet the needs of war mobilization, the government needed not only a new ministry but also concrete policies that would give the people access to health care. Health insurance became part of these policies. Once it realized by early 1938 that the war against China would last longer than initially anticipated, the Japanese government paid more attention to health insurance as a national defense measure. But the government did not go beyond moderate reforms before 1940, because the war was still limited to China and did not require a drastic policy change to meet mobilization needs. In this period, these reforms took the form of four measures: the National Health Insurance Law of 1938 (Kokumin Kenkōhoken Hō), the White-Collar Workers' Health Insurance Law of 1939 (Shokuin Kenkōhoken), the Seamen's Insurance Law of 1939 (Sen-in Hoken Hō), and public health care for injured soldiers.

In the 1920s, Japan suffered from economic stagnation. In particular, the living conditions of farmers deteriorated as a result of rapid industrialization, the post–World War I recession, and the worldwide depression triggered by New York's stock market crash in 1929.[28] In addition, the spread of epidemic and chronic diseases, especially tuberculosis, devastated the rural population. The Manchurian Incident in 1931 boosted the Japanese economy by causing a mini–war economy for a short period of time, but it did not improve the economic conditions of the rural population. The death rate from tuberculosis decreased slightly, but it started to increase again in 1933.[29] At that time, it was often the case that farmers saw a doctor only when death certificates were needed.[30]

In April 1933, the Social Affairs Bureau of the Home Ministry began to study health care for farmers. After about a year, the Social Affairs Bureau released a draft of a national health insurance program for farmers to solicit comment.[31] The JMA blocked the plan, however. Suzuki Hitoshi, a representative of the JMA, argued in September 1934, "I see that the Health Insurance Law of 1922 has had problems and been ineffective. It will cause further tragedy and danger if we have a large-scale health insurance program."[32] The JMA, frustrated by the

administration of the Health Insurance Law, opposed any further governmental intervention in health care finance.

The fight between reform bureaucrats and the JMA continued. In October 1935, the Home Ministry asked the Social Security Investigation Committee (Shakai Hoken Chōsa kai) for a more detailed plan of health care for farmers, and the committee submitted a report on the issue to the Home Ministry, mentioning that "health insurance for the rural population is needed for solving deteriorating social conditions."[33] However, the JMA again campaigned to oppose the committee's proposal. It used the Home Ministry's intra-ministerial conflict, especially between the Public Health Bureau and the Social Affairs Bureau, to kill the proposal. When the Social Affairs Bureau proposed the National Health Insurance (NHI) bill in 1936, moreover, the JMA sent telegrams to the Bureau charging that "the National Health Insurance will kill all of us."[34]

On April 11, 1938, over the JMA's opposition, the NHI passed in the Imperial Diet as the first bill introduced by the newly created MHW as a wartime necessity. The Marco Polo Bridge Incident in July 1937 turned the idea of health care for farmers from an individual- or social-level problem into a national defense problem, because farmers were a critical source of enlisted men; the military recruited about 85% of its men from the countryside.[35] Although a conscription system had been instituted in 1873, the military had relied mostly on volunteers, except in the case of major international wars, such as the Sino-Japanese War (1894–95) and the Russo-Japanese War (1904–5). But in late 1937, the military began planning to draft many conscripts for an extended time.[36]

Furthermore, farmers' sons and daughters were also sent to factories in urban areas. Koizumi Chikahiko emphasized in 1938 that "because industry and agriculture are deeply related, the manpower problems in industry and agriculture cannot be solved independently from one another."[37] As a result, the issue of farmers' health was argued not only from the point of view of improving the welfare of agricultural workers but also from the desire to create a reservoir of human resources for the war.[38]

Kido Kōichi, the first health and welfare minister, summarized the impact of the war against China on the creation of the NHI: "The origin of this National Health Insurance bill did not have a direct link with the war in China. However, we now need to pass the bill in preparation for the long-term fight in China. The improvement of people's bodies and spirit would make it possible to overcome any obstacles in the long fight. It is more crucial in this national emergency than in peacetime to improve medical facilities and extend the coverage of the National Health Insurance Law."[39]

The NHI targeted the self-employed, such as agriculture and fishery workers. While the Health Insurance Law of 1922 initially covered about two million people, the NHI would potentially cover about fifty million people, 71% of the population. Newly established quasi-public National Health Insurance associations (*kokumin kenkō hoken kumiai*) and the existing private medical cooperatives (*iryō riyō kumiai*) were used for the NHI's administration. Most of them were region-based organizations, unlike the Health Insurance Law, which was a workplace-based program. These administrative bodies had a great deal of discretion, including control over premiums and benefits; as a result, some of the National Health Insurance associations provided less generous medical services than others. The government supervised the program administration and provided the financial support for administrative costs.[40]

Even as it promised possible large coverage, flexible administration, and government subsidies, the NHI faced a financial obstacle to swift expansion. First, because, unlike workers under the Health Insurance Law, farmers and other self-employed people did not have employers, the NHI had to depend almost entirely on the enrollees' contributions. The government's subsidy did not cover what the employers would contribute under the Health Insurance Law. Second, the former was a voluntary program: the establishment of its administrative associations and enrollment were voluntary. This was the most important difference between the NHI and the Health Insurance Law. Because it basically relied on voluntarism, the program suffered from an adverse selection problem: sick people were more likely to enroll in the program. This dynamic weakened the NHI financially. Consequently, NHI beneficiaries were required to make large co-payments, from about a third to half the cost, a specification that did not exist at all in the Health Insurance Law.[41]

The NHI was, in a sense, the minimum that the JMA could bear. The JMA eventually had to accept the establishment of the NHI in the midst of the war, but it gained a compromise to fragment the administration of the NHI and make participation in the NHI noncompulsory. In addition, the JMA was successful in preventing the creation of new medical cooperatives, which in rural areas were privately organized; the NHI allowed only existing medical cooperatives to administer the NHI. Lastly, in the discussion of the NHI bill, the JMA won an assurance that the NHI "would not destroy the system of private solo practitioners but stabilize it."[42] Regarding the fragmented and voluntary characteristics of the NHI, Shimizu Gen, the person most responsible for the drafting of the NHI, also noted that it aimed at "responding to the various local situations."[43]

But the JMA "never lost the cautiousness or distrust of the national health insurance system."[44] In fact, the government continued to seek the expansion of health insurance as a means of national defense. But the radical change in health insurance, which was to make the NHI compulsory, nationalize hospitals, and put the JMA under government management, had to wait until 1942, when the government needed a larger mobilization for the war.

In retrospect, two small programs for civilians established in 1939 turned out to be precursors to the radical policy change after 1942. In 1938, the government did not have the means of breaking the deadlock in the war with China. Kido Kōichi, the minister of health and welfare, said in December 1938, "The war in China has become a long war. We need to produce more behind-the-gun measures."[45] Shindo Seiichi, head of the Board of Insurance, also noted in January 1939: "The war developments in China last fall have necessitated a long-term war plan. . . . Health insurance programs help strengthen our spirit and health for winning the war."[46]

The White-Collar Workers' Health Insurance Law was created in February 1939 to respond to the new war situation by expanding health insurance coverage and strengthening the government's authority in health care. It was a compulsory program to provide health insurance for non-manual urban laborers in companies of ten or more employees. The targeted workers typically worked in sales, finance, insurance, and advertising. Hirose Hisatada, undersecretary of the MHW from January 1938 to January 1939 and its minister from January 1939 to August 1939, stated in the Imperial Diet that the White-Collar Workers' Health Insurance Law should be established "for strengthening human resources for the front and behind-the-gun activities in this national emergency."[47] The White-Collar Workers' Health Insurance Law was established as a supplement to the Health Insurance Law of 1922, targeting office workers that the Health Insurance Law did not cover. Unlike the Health Insurance Law, which did not ask for co-payments, the White-Collar Workers' Health Insurance Law required a co-payment of 20% of the cost of care. It also set a new fee schedule; the fee-for-service payment system was based on the government's point system (*kinrō teigaku shiki*). Under the system, individual doctors were paid depending on what medical services they provided, while the Health Insurance Law paid the local medical associations based on how many enrollees they had (*jintō ukeoi shiki*). This change in the fee schedule, according to Kawakami Takeshi, allowed the government to reduce the power of the JMA and restrain the cost of medical services. The program covered 674,000 people in the first year.[48]

The second law passed in 1939 was the Seamen's Insurance Law.[49] The government got seriously involved in the health of seamen as early as 1921, when the Post Office Insurance Bureau in the Ministry of Communications and Transportation submitted the outline of the Seamen's Insurance bill. But the creation of the Seamen's Insurance Law had to wait until the war with China made the government order further war mobilization, a development that made seamen strategically important for the war. Hirose, for example, argued that "Japan is surrounded by sea. Because seamen play a large role in national defense, it is crucial to let the seamen continue to work with security."[50] The Seamen's Insurance Law was different from the other national health insurance programs in that it was the first public program that provided comprehensive social security benefits, including health insurance, pension benefits, and life insurance. It insured 102,000 people when the program started.[51]

As public health insurance gradually increased its coverage, the government expanded public health care for injured soldiers and their families. In March 1937, the Military Assistance Law (Gunji Fujo Hō) was enacted to replace the Military Relief Law created in 1917. Under the new law, those who had a wider range of service-connected injuries and their more distant family members were included. Moreover, the means test became less restrictive, changing from "those who cannot make a living" to "those who have difficulties in making a living."[52] With these changes and the war with China, the beneficiaries of the program jumped from 1,357,557 in 1937 to 2,107,327 in 1938.[53]

The war with China led the government to strengthen the administration dealing with injured soldiers. As the war with China expanded and caused more casualties, in January 1938 the government was urged to set up the Advisory Council for the Assistance of Injured Soldiers (Shōi Gunjin Hogo Taisaku Shingikai). The newly created Ministry of Health and Welfare sent an inquiry about injured soldiers to the council. It suggested improvement of care for injured soldiers and compensation for caregivers, care providers, and facilities such as hot-spring therapy homes, tuberculosis sanitaria, and mental-health sanitaria. In April 1938, the Institute of Assistance for Wounded Soldiers (Shōhei Hogo In) was established as an extra-ministerial body to the MHW. The institute took the lead in expanding the medical facilities for injured soldiers.[54]

In sum, the NHI, the White-Collar Workers' Health Insurance Law, and the Seamen's Insurance Law were major pieces of legislation developed in response to the war after July 1937. The government also increased public health care for injured soldiers. They were, however, still far from a drastic reform. The NHI was established as a voluntary program. The White-Collar Worker's Health

Insurance Law and the Seamen's Insurance Law targeted particular occupational groups that made up a limited segment of the population. None of the health insurance programs, furthermore, proposed radical reorganization of health care providers. When Japan expanded its war from China to other areas and came into direct conflict with the interests of the Allied Powers, however, the government moved toward more comprehensive health insurance reform.

ACHIEVING RADICAL REFORM, JULY 1940–AUGUST 1945

The war situation changed drastically when the Japanese government decided to expand the war front from China to other Asian regions. In July 1940, Konoe Fumimaro formed his third cabinet and introduced the idea of the Greater East Asia Co-Prosperity Sphere (Daitōa Kyōeiken) in July 1940. His idea gained strong support from the Army, which was seeking to secure the natural resources in Southeast Asia. In September 1940, Japan signed the Tripartite Pact with Italy and Germany and thus became part of a military coalition against the Allied Powers. Figure 3.2 shows that the rate of war mobilization drastically changed in 1940 and 1941.[55] Now the government had to mobilize not only many more young men to send to the battlefields but also the rest of the able-bodied population to produce munitions; national morale also became a pressing issue. As the government projected a devastating war with the Allied Powers, it shifted its policy preference in health care from moderate reform to

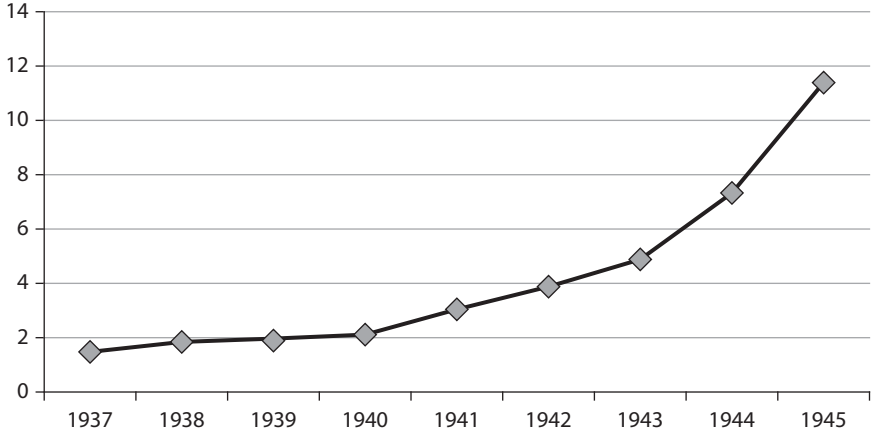

Figure 3.2. Mobilization Rate of Japan, 1937–1945.
Sources: For military personnel, Kanbō, ed., *Naikaku Seido 70 Nenshi,* 565. For the population, Kōseishō Gojūnenshi Henshū Iinkai, *Kōseishō Gojūnenshi: Shiryō Hen,* 621.

radical reform. Furthermore, the war situation politically strengthened the government and weakened the Japan Medical Association.

The Government's Power in an Escalating War

The period after the establishment of the NHI helped the government to prepare for further expansion of the government's authority in health care. In July 1938, the government set up the Medical Care and Pharmaceutical System Investigation Committee (Iyakuseido Chōsakai) headed by the minister of health and welfare.[56] The council submitted a report in October 1940 recommending more governmental control over physicians by restricting new construction of private hospitals and clinics, designating insurance doctors, and establishing public medical facilities in villages that had no doctors. The report also suggested that the JMA serve a public purpose, that all doctors join the medical association, and that the cabinet appoint the president of the JMA.[57]

The JMA was wary about the Pharmaceutical and Medical Care Investigation Council's goals. In December 1938, the JMA expressed its serious opposition to a tentative proposal from the council that suggested that Japan should take steps to put the medical system under government management: "Japan's practitioner system is based on the mutual fidelity between doctors and patients, which is an admirable tradition in Japan. . . . Considering the plan, which won't bring happiness to the people or to the doctors, the government should draft people and train them to be doctors. Otherwise, no one would like to be a doctor."[58]

But the JMA's resistance was blunted by Koizumi Chikahiko. Koizumi, who had been director of the Army's Medical Care Bureau and had worked hard to create the Ministry of Health and Welfare, sought to realize the public management of medicine. In July 1941, Koizumi became minister of health and welfare: his and the Ministry of War's long-cherished desire was now fulfilled. He introduced the slogan "healthy soldiers, healthy people" (*kenmin kenpei*) to push for radical reform of the health care system.[59] To him, the existing health care system that relied on private doctors was not adequate to deal with epidemic diseases or the poor.[60] During his first interview with medical reporters as minister in June 1941, he claimed, "Some of the doctors had a great sense of security in seeing me, a medical doctor, in the position of the Minister of Health and Welfare. However, their expectation is wrong; instead, I will bring completely opposite results."[61] The turn in the war planning in 1940 encouraged him to push for comprehensive reform in health insurance.

The changing war situation also affected the government's population policy. Before the war, the government was planning to reduce the population because Japan lacked natural resources. By 1940, however, necessities of the war changed the government's perception from one of population excess (*jinkō kajō*) to one of population shortage (*jinkō kashō*). While in April 1940, the National Physical Strength Law (Kokumin Tairyoku Hō) and the National Dominant Heredity Law (Kokumin Yūsei Hō) were established for improving the population "qualitatively," a "Give Birth for the Nation" (*umeyo huyaseyo*) policy was implemented for increasing the size of the population.[62] A cabinet meeting in January 1941 proposed a policy for increasing the population to 100 million by 1960 from 72 million in 1941. It also suggested that in order to achieve that goal, the government should expand the national health insurance coverage to the entire population and cover not only curative treatment but also preventive treatment.[63]

The combination of the Investigation Committee's report, Koizumi's determination to bring about reform, and the changing war situation led to the National Medical Care Law (Kokumin Iryō Hō) of February 1942. Its first article stated, "This law aims at improving the people's health by reforming the medical system."[64] The law had four goals that changed the longstanding Medical Rules and Regulations (Isei), which had been established in 1874. First, the new law restricted private hospital construction and provided the government with the authority to purchase existing private hospitals. Second, it promoted the expansion of public hospitals, particularly in villages without doctors. Third, it granted the government the authority to educate medical professionals and control medical associations. Finally, to achieve these goals, the National Medical Care Law allowed the government to establish the Japan Medical Corporation (Kokumin Iryō Dan). The corporation began to operate in April 1942 and became a means for the government to exert control over the health care system.[65]

In the meantime, the JMA came under public attack. Already in 1939, an editorial in *Asahi Shimbun,* a major newspaper in Japan, stated, "The reform in the medical system requires the regeneration of liberal principles or professional ethics. Medicine belongs not to doctors but to the public. Doctors should work for the nation as semi-public servants."[66] In June 1941, Koizumi made comments about reforming the JMA in an interview with medical reporters: "Of course, the reform is urgent. We are in a new era. We have to change the old system. Reform! Right now! The JMA must immediately have its own reform for adjusting to the new era. Otherwise, the government will impose reform on the JMA."[67]

The JMA found itself already enmeshed in war mobilization. In 1941, the Ordinance for the Conscription of Medical Personnel (Iryōkankeisha Chōyōrei) was issued to increase the government's power to draft doctors for war activities. The war gave the government more power to make individual doctors and the JMA help with the government's war activities. At its peak in 1941, the number of doctors practicing in the homeland was 67,612. That figure decreased to 50,677 in 1942, to 34,423 in 1943, and to 11,136 in 1944.[68]

While the JMA lost its political power, the political structure also became more centralized. In October 1940, Prime Minister Konoe Fumimaro created the Imperial Rule Assistance Association (Taisei Yokusankai), a political party to abolish all sectionalism in the economy, society, and politics and to make war mobilization more efficient. Under the new political system, all political parties ceased operation, and civil associations began to operate part of the government's war mobilization efforts. Although the Imperial Rule Assistance Association soon faced criticism and never gained the dictatorial powers that Konoe initially anticipated, it influenced how political and social actors saw the government and the war.[69] Along with youth organizations and women's organizations, in November 1941 senior members of the JMA, such as Sata Aihiko, Hayashi Haruo, and Taniguchi Yasaburō, sought to honor the new circumstances by amalgamating the JMA with the Imperial Rule Assistance Association.[70]

In August 1942, as war mobilization continued to increase, the government issued an ordinance about the JMA and the Japan Dental Association (Ishikai oyobi Shikaishikai Rei) to clarify the provisions about medical associations in the National Medical Care Law. The ordinance stipulated that the JMA be reorganized as a new association, which all physicians would be compelled to join. In addition, the MHW would nominate and the prime minister would appoint the president of the reorganized JMA.[71] Finally, the ordinance also indicated that the new JMA should cooperate with the Japan Medical Corporation. When Inada Tatsukichi, the first president of the Japan Medical Corporation, was appointed president of the JMA, the JMA completely lost its independence from the government. *Yomiuri Shimbun* wrote that the JMA had to "eliminate the spirit of its traditional liberal guild organization and cooperate with the Japan Medical Corporation."[72] As Miwa Kazuo put it, when JMA President Kitajima Taichi stepped down, "liberal tradition by Fukuzawa Yukichi, Kitazato Shibasaburō, and Kitajima Taichi died out."[73]

In sum, the government drastically changed its war plans in July 1940. After Konoe proposed that Japan expand the front outside China, the government had to mobilize many more people without knowing when the devastating war

would end. Koizumi sought more control over the JMA to create a more efficient and effective medical care system. The deepening war situation thus gave power to the government. The National Medical Care Law and the Japan Medical Corporation were responses to the new war situation after the summer of 1940.

Radical Reform in Health Insurance

The period from 1940 to 1942 was the turning point for the expansion of health insurance. As the war front spread and more soldiers were drafted, the government sought to stress the importance of health insurance as a means to fight the war. By 1942, the government faced a serious problem in filling the need for manpower.[74] But the change in the war situation gave the government more authority in health insurance. The government was able to amend the Health Insurance Law and the National Health Insurance Law. By 1944, the government leadership had gotten the national health insurance programs to cover more than 70% of the population.

Koizumi Chikahiko was the central figure in expanding national health insurance. Koizumi helped get the Ministry of War and the Ministry of Health and Welfare to join in amending national health insurance programs. Although both ministries had different motivations—the former focused more on policies directly connected with the military—they shared an interest in pushing for the expansion of national health insurance. In January 1942, Hirai Akira, head of the Board of Insurance in the MHW, explained the purpose of expanding national health insurance: "We have no goals other than winning the war. . . . The ultimate goal of national health insurance programs is to produce 'healthy soldiers, healthy people.' The programs secure the most important thing in war mobilization, human resources. Healthy soldiers go to the front to beat the United States and Great Britain; healthy people maintain efficient munitions production."[75] Zaitsu Yoshifumi, a high-ranking officer in the MHW, also noted that the changing war situation affected national health insurance: "We need to mobilize three million soldiers in order to satisfy all current needs abroad, but it is extremely difficult to mobilize such numbers. It is crucial to increase our population. But as a short-term goal, we need to decrease the ratio of workers needed to support one soldier. . . . Administrating health insurance programs provides us with the necessary statistics to produce appropriate policies for improving the efficiency of workers."[76] The war created a way that would never have occurred in peacetime for the Ministry of War and MHW to expand national health insurance and its own political power.

The Health Insurance Law was amended in February 1942. The amendment extended benefits to workers in smaller firms, reducing the requirement of having more than ten employees to five employees, and it stipulated the expansion of the Health Insurance Law's benefits to workers' dependents. Furthermore, it incorporated the White-Collar Workers Health Insurance Law of 1939. The merger changed the nature of the Health Insurance Law. The Health Insurance Law adopted co-payments and the government-controlled fee-for-service payment system of the White-Collar Workers' Health Insurance Law. Before the amendment, the Health Insurance Law had included a fixed capitation provision over which the JMA had considerable power in the annual negotiation with the government. Therefore, according to Kawakami Takeshi, the change to the fee-for-service system showed the government's intention to diminish the JMA's power and to extend its own control over health insurance finances.[77] While doctors held up the fee-for-service system as an important element to be independent from the government in the United States, in Japan the government sought to expand its power to reduce health care expenditures by creating a new public fee-for-service system.[78]

The government also changed the NHI in February 1942. In contrast to the Health Insurance Law, the White-Collar Workers' Health Insurance Law, and the Seamen's Insurance Law, the NHI was initially established as a voluntary program. When the NHI was established, the MHW had a ten-year plan for the gradual expansion of the NHI. As seen in Table 3.1, the achieved number of insured did not go much beyond the projected number until 1940. But after 1940, enrollment exceeded the projections. It was estimated that the NHI would cover 18 million people in 1945, but it actually was covering about 41 million

TABLE 3.1.
Expansion of the National Health Insurance in Japan, 1938–1945

Year	Projected number of insured	Achieved number of insured
1938	500,000	523,223
1939	1,500,000	1,313,484
1940	3,000,000	3,045,046
1941	5,000,000	6,704,992
1942	7,500,000	22,661,192
1943	10,500,000	37,959,663
1944	14,000,000	41,161,301
1945	18,000,000	40,925,424

Source: Shō, *Nihongata Fukushi Kokka no Keiseito Jūgonen Sensō,* 121–22.

people by that time. This dramatic increase in coverage reflected the changing nature of the war.

The change in NHI was to make the establishment of National Health Insurance associations mandatory and to require almost all people not covered by other health insurance programs to participate in the NHI. In October 1941, Koizumi declared that Japan would have National Health Insurance associations in all municipalities in three years. He proposed the slogan "all people should have insurance" (*kokumin kaihoken*), which was adapted from the wartime slogan "all people are soldiers" (*kokumin kaihei*), and emphasized that universal health insurance would be necessary for the nation in wartime.[79] The government utilized the Imperial Rule Assistance Association to coordinate its efforts to expand health insurance.[80] By the time Japan surrendered, National Health Insurance associations existed in an estimated 95% of all municipalities.[81]

The NHI amendment of 1942 severely damaged the JMA's political power against the government. In addition to making the people's participation in NHI compulsory, the amendment prohibited doctors from refusing to practice in the NHI system. The amendment also gave the minister of health and welfare the authority to set doctors' fees and to inspect the medical records of the practitioners. Finally, in November 1942, the government promoted the Board of Insurance to the Bureau of Insurance to extend its administrative authority in health insurance.[82] As a result, the amendment gave the government more power over the JMA.

The government continued to increase its control over doctors' fees. In February 1943, the government decided to use the same standard fee calculation, which was based on the one used in the Health Insurance Law, for all public health insurance programs. To set doctors' fees, the Ministry of Health and Welfare had asked the JMA, the Japan Dental Association, and the Japan Pharmaceutical Association for advice. As the war went on, the government got frustrated by the demands of these associations. In response, in June 1944, the government created the Committee on Health Insurance Medical Fees (Shakai Hoken Shinryōhōshū Santei Iinkai) in the MHW to discuss and suggest doctors' fees. This committee was made up of eleven people from doctors' associations; eleven people from public hospitals, National Health Insurance associations, and others; and eleven bureaucrats. Under this arrangement, the JMA lost its power to negotiate doctors' fees directly, and the government gained more authority over the JMA.[83]

In sum, 1940 was the critical moment in the development of health insurance in Japan. Deciding to fight the Allied Powers meant that the government would need far more manpower in pursuing the war, with no way of knowing how long the war would last. In response to the increasing demands for manpower, the government achieved a radical reform of national health insurance. The government's pre-1940 policy discussion helped it realize radical reform after 1940. The government officials had studied health insurance so much that it swiftly produced policy proposals when the war situation changed. The rapid increase of national health insurance coverage later amazed an officer in the American occupation authority in Japan: "There were no other examples in the world like the rapid increase of national health insurance in wartime."[84] This rapid increase reflected the transformation of the war after the summer of 1940.

CHAPTER FOUR

Forming a Hybrid Health Insurance System

The United States, 1941–1945

President Franklin D. Roosevelt asked Congress to declare war on December 8, 1941, stating, "Yesterday, December 7, 1941—a date which will live in infamy—the United States of America was suddenly and deliberately attacked by naval and air forces of the Empire of Japan."[1] Japan's attack on Pearl Harbor officially brought the United States into World War II. By that time, however, the American government had begun war preparations in response to the situation in Europe.

When the United States recognized that Germany's aggressiveness could not be resisted by Great Britain alone, it began a serious preparation for a long and full mobilization. As the plan for a large-scale mobilization commenced, federal officials in health care and the military pushed for the establishment of universal health insurance.

However, by the end of 1943 the tide of the war changed, and the government foresaw that the war would soon be over. This change reduced the urgency to create universal health insurance. While the movement for universal health insurance rose and fell, however, more and more military-related personnel had access to public care, and more and more civilians were covered by private health insurance. As a result, by the end of the war, without universal health insurance, the United States had formed a hybrid health insurance system composed of public health insurance for select groups and private health insurance for those who could afford it or whose employers could afford it.

MOVING TOWARD RADICAL REFORM, 1941–1943

When the federal government projected that the United States would soon enter the war and require a large-scale mobilization, it began to coordinate military and nonmilitary agencies that dealt with health care. Then the actual entry into the war radically deepened mobilization and led some government officials to plan policies to improve the health of draftees, war industry workers, and the rest of the population to make war mobilization more efficient. In contrast to the federal government's increasing role in health care, the AMA lost its power to oppose the government's authority in health care. From 1941 to 1943, expectations of the duration and intensity of the war encouraged the federal government to expand its authority in health insurance.

The Empowered Government in Health Care

Germany triggered World War II by invading Poland on September 1, 1939. In response to Germany's invasion of Poland, Roosevelt declared a limited national emergency on September 8. Adolf Hitler continued his aggression, overrunning the Low Countries—Belgium, the Netherlands, and Luxembourg—and invading France in May 1940. At that time Great Britain stood alone, and it suffered German air attacks beginning in the early summer of 1940.

To coordinate the preparation for the war, Roosevelt created the Office of Emergency Management in the Executive Office of the President "to maintain coordination between the President and whatever defense agencies would be established."[2] He also created the National Defense Advisory Council for business leaders and government officials to discuss and supervise munitions production. In January 1941, furthermore, Roosevelt reorganized the National Defense Advisory Council as the Office of Production Management to give more authority and to centralize the government's economic mobilization.[3] The radical expansion of the defense industry from 1940 to 1941 forced the government's institutional coordination; occupying only 1.7% of the GNP in 1940, it expanded to 5.6% in 1941 and to 17.8% in 1942.[4]

In addition to coordinating industrial policy, the government gained the power to compel Americans to sacrifice their lives in battle. For the first time in the U.S. history, the conscription system was established without an official declaration of war. In September 1940, Congress passed the Selective Training and Service Act. Immediately afterwards, the Selective Service System came into operation as a national organization for recruitment. It was also responsible for

the physical examination of draftees. Lewis B. Hershey, then a lieutenant colonel, was appointed as its head and remained in the position during the war. On the same day, Roosevelt issued a proclamation for the registration of all male citizens between 21 and 36 years of age who were living in the United States.[5]

In the spring of 1941, the federal government suggested a clear change in its foreign policy toward the war in Europe. In March, the Lend-Lease Act provided the president with the authority to sell, transfer, exchange, and lend equipment to any country defending itself against the Axis Powers. On May 27, 1941, Roosevelt declared an unlimited national emergency in response to British disasters in the Mediterranean in the spring of 1941 and, more directly, to the sinking of an American merchant ship, the *Robin Moore,* by Germany on May 21. In the summer of 1941, Congress passed legislation to remove the ceiling of draftees, which was then at 900,000. When Roosevelt put together a Victory Program in the summer of 1941, he projected a mobilization of approximately 9 million military personnel for the war to come.[6]

As the government conducted serious preparations for war, peacetime health care institutions were enlisted in war mobilization. In the summer of 1941, for example, the heads of the Public Health Service and the Children's Bureau were named to serve on the Advisory Commission to the Council on National Defense. The Social Security Board, furthermore, maintained a close relationship with the Department of War and the Departments of the Navy, the Selective Service System, and other military agencies in order to coordinate war mobilization.[7] In its Annual Report of 1940, the Social Security Board for the first time clearly stated the relationship between social security and national defense: "Whatever the future course of international affairs, the social security program embodies national defense in a war that is unremitting."[8]

After the United States officially entered the war in December 1941, the federal government needed more and more people for the war. As Figure 4.1 shows, the number of military personnel exceeded Roosevelt's prewar estimates; in 1943, the percentage in the United States almost reached the level in Japan in 1944. To coordinate war mobilization, in January 1942 President Roosevelt established the War Production Board by merging the Supply, Priorities, and Allocation Board and the Office of Production Management. In discussing its establishment in a congressional committee, a Senate report stated, "We are fighting an entirely new kind of war. . . . War today involves our entire economy."[9] Donald Nelson, who was a liberal but was also trusted by conservatives, ran the War Production Board.[10] After the establishment of the War Production Board, many claimed that it would be necessary to create an agency that

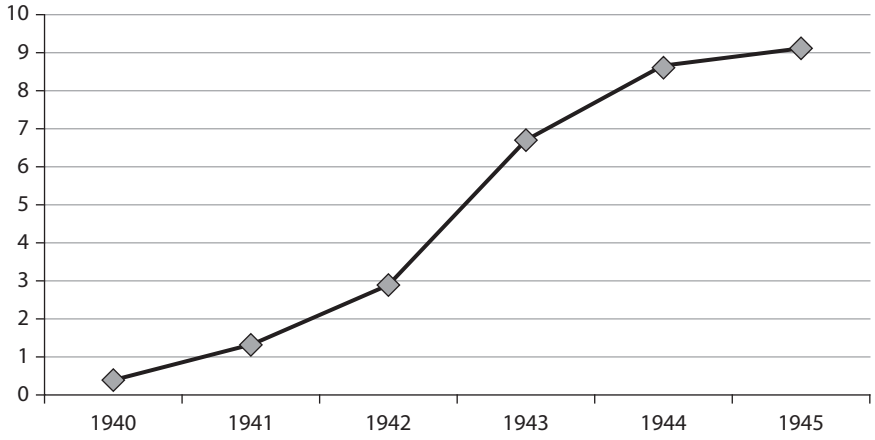

Figure 4.1. Mobilization Rate of the United States, 1940–1945.
Source: U.S. Department of Commerce, *Historical Statistics of the United States,* 18, 1141.

specialized exclusively in manpower issues in order "to coordinate the war manpower agencies and to affect more direct cooperation."[11]

On April 18, 1942, the president established the War Manpower Commission (WMC) to achieve this goal. Based on the authority given by the Constitution and other statutes, including the First War Powers Act of 1941, the WMC aimed at "assuring the most effective mobilization and utilization of the national manpower."[12] The WMC was composed of representatives of the Department of War, the Department of the Navy, the Department of Agriculture, the Department of Labor, the War Production Board, the Labor Production Division of the War Production Board, the Selective Service System, and the U.S. Civil Service Commission. Paul V. McNutt, who was the federal security administrator, was appointed chairman of the WMC, and Arthur Altmeyer, the chairman of the Social Security Board, served as its executive director.[13]

Despite the government's efforts to coordinate institutions that dealt with war mobilization, the manpower shortage increasingly became a serious problem. Already by late 1941, the defense industry faced a shortage of skilled workers: the manufacturing industries paid about 20% more in November 1941 than in November 1939 to secure their skilled workers.[14] As the manpower shortage continued, in April 1942 the Selective Service System conducted a fourth conscription registration for all males between 45 and 65 years of age.[15] In December 1942, furthermore, the age cutoff of inductions for male conscripts was changed from 20 to 18.[16] By December 1942, the increased demand for human resources by war industries and the armed forces absorbed most of the

TABLE 4.1
Transformation of labor distribution in the war economy in the United States, 1940–1943

	Dec. 40	Dec. 41	Dec. 42	Dec. 1943 (estimated)
Armed forces	800,000	2,100,000	6,200,000	10,800,000
War industry	1,500,000	6,900,000	17,500,000	20,000,000
Agricultural workers	8,700,000	8,300,000	8,900,000	8,900,000
Non-war workers	31,500,000	29,200,000	21,400,000	19,000,000
Self-employed (professional, etc.)	5,900,000	5,800,000	4,100,000	3,500,000
Unemployed	7,100,000	3,800,000	1,500,000	1,000,000
Total	55,500,000	56,100,000	58,600,000	63,200,000

Source: Selective Service System, *Selective Service in Wartime: Second Report of the Director of Selective Service* (Washington, DC: U.S. Government Printing Office, 1943), 357.

unemployed and many of the workers in non-war-related sectors (see table 4.1). The increasing war mobilization pressed McNutt to balance the distribution of manpower between the industries and the armed forces.[17] The Selective Service System warned in late 1942 that "our superabundant resources of manpower and material were now being tested. Our human and material resources are not unlimited. They must be conserved; they could not be wasted."[18]

Responding to the decrease in available human resources, Roosevelt issued an executive order to reorganize the WMC in December 1942. The most important change was that the Selective Service System was transferred to the WMC while the functions, powers, and duties of the director of the Selective Service System were shifted to the chairman of the WMC.[19] The WMC, however, still faced internal disputes, especially between McNutt and the Department of War and the Department of the Navy over the distribution of manpower, the former emphasizing the war industries and the latter the armed forces.[20] As war mobilization increased, it became evident that the WMC could not be the solution for making war mobilization more efficient.

Frustrated by the situation, Roosevelt increasingly came out in favor of a labor draft, which would give the president the authority to distribute manpower wherever it was needed. As early as April 1942, he directed McNutt to form a subcommittee within the WMC to produce a proposal for a labor draft.[21] In February 1943, Congress started debating the possibility of introducing such a bill.[22] A poll suggested that by early 1943 Americans were ready for the labor draft "if it is essential." In addition, "in time of emergency," Charles E. Martz, editor of *Our Times,* noted, "the survival of the Nation surmounts all individual rights. The Supreme Court has repeatedly upheld the military draft, and it

would surely uphold a labor draft for the duration."[23] As George Q. Flynn has also pointed out, "Most decisive to the political minds of men such as [Harry] Hopkins and [James] Byrnes was the simple fact that such a law had little chance of passing Congress until the American people had been 'conditioned' to such a radical step by Roosevelt. . . . As the war effort expanded Stimson felt sure national service would become inevitable."[24] By the end of 1943, the United States was driven to the very edge of facing a deep shortage of human resources in war industries. In these circumstances, the government gained more justification to get involved in distributing industrial workers and improving the health of workers to make war mobilization more efficient.

In contrast to the federal government, the AMA increasingly found itself on the defensive. The AMA traditionally insisted on its autonomy to practice medicine, but the war put a priority on a common interest, winning the war, rather than the narrower interests of the AMA. The AMA had to adjust its goal to the national interest. Many AMA members, mostly private individual practitioners, got physically involved in war-related activities, such as serving as military doctors in the field and at base hospitals, as physical examiners at local induction boards, and as medical researchers.[25] In the spring of 1942, McNutt and Frank Lahey, the president of the AMA, presented facts showing that the armed forces needed over two-thirds of the 80,000 physicians under the age of 45 and over one-third of all active doctors. The mobilization meant that "civilian medical practice will be upset as never before in American history."[26] In 1943, John Perrott and Burnet M. Davis, of the U.S. Public Health Service, wrote about the effect of losing doctors to the war: "How long the war will last we do not venture to predict, but it appears evident from the present medical training program that the Army and Navy expect to require large numbers of medical officers for a considerable number of years."[27]

The AMA as an association was also enmeshed in the government's mobilization efforts. The Procurement and Assignment Service for physicians, dentists, and veterinarians was created in October 1940, and the president of the AMA became its chairman. The Procurement and Assignment Service was under the supervision of McNutt, then the federal security administrator and the director of defense, health, and welfare services in the Office of Emergency Management. Although the Procurement and Assignment Service did not initially possess coercive power, it made suggestions about how to solve the unbalanced distribution of doctors in the country.[28] Soon after Pearl Harbor, the Procurement and Assignment Service began to face difficulties in securing sufficient doctors, because of the rapid increase in demand for doctors in the

armed forces. In June 1942, McNutt, in his address to the House of Delegates of the AMA, argued, "The voluntary plan must work and work promptly—or some other more vigorous plan will have to be produced."[29]

In sum, in the spring of 1941, the federal government initiated serious preparatory activities for deep mobilization without knowing when the war would be over. As the government projected that war mobilization would exhaust existing human resources, it developed institutions to allocate manpower for the armed forces and war industries. Roosevelt accordingly considered more direct control over human resources, including a labor draft. As war mobilization increased, doctors were also brought into war activities, and the AMA became enmeshed in the government's war planning. As the government gained power over manpower distribution, therefore, the AMA had less independence from the government than it had had in peacetime. When the government gained the authority to coordinate and centralize health care institutions and the AMA's power decreased, the window of opportunity began to open for reformers to expand public health insurance.

Expansion of Private and Public Health Insurance

From 1941 to 1943, the worsening war situation spurred the federal government to increase the mobilization of material and human resources. As a full mobilization plan was being implemented, the United States strengthened the movement for radical reform in health insurance. Like Japan, the United States also noticed that many men were failing their physical examinations for conscription; in fact, approximately the same percentage of draftees failed their physical exams at the beginning of the war in the United States as in Japan. Under the circumstances, reformers sought to connect war mobilization with health insurance and pushed for the expansion of public health insurance. But World War II brought different policy outcomes to the two countries. While Japan adopted near-universal public health insurance, the United States expanded public health insurance for select groups—such as the families of servicemen, veterans, and farmers—and private health insurance for those who could afford it.

As an urgent response to the needs of men drafted into the armed forces, the federal government got involved in maternal and infant care for the dependents of servicemen, services that set the soldiers at ease about the security of their families. In 1942, state and local governments sent petitions to the Children's Bureau for federal funds to offer maternal and infant care for the wives and in-

fants of servicemen. By March 1943, the federal government was urged to deal with the fact that eleven states had exhausted the granted funds.[30] The First Deficiency Appropriation Bill for 1943 included an appropriation of 1.2 million dollars for the remainder of the 1943 fiscal year. Known as the Emergency Maternity and Infant Care Program (EMIC), it helped state governments provide wives and infants of the four lowest grades of servicemen with generous obstetrical and pediatric care without means tests.[31] Wives of servicemen could have medical services including up to five prenatal examinations and at least ten-day hospital care. They were also free to choose their own doctors from a list of registered doctors. State health departments and the Children's Bureau jointly approved the EMIC's fee schedule. It was estimated that 20% of the one million servicemen were married and that at least 5% of births in 1943 and 10% in 1944 were by wives of servicemen. Congress approved $4.4 million for the 1944 fiscal year to fund the program. By the time the EMIC was abolished in 1947, its expenditures had reached $130 million, and it had given care to 1.2 million maternity patients.[32]

Roosevelt signed the bill on March 18, 1943. "The impact of war upon family life," he said, "has created urgent needs which previously authorized Federal appropriations combined with state and local funds have not been able to meet."[33] Martha Eliot, associate chief of the Children's Bureau in the Department of Labor, wrote, "History shows that during wars nations become aware of the need for legislative action to assure the future of their children."[34] The creation of the EMIC was also encouraged by the rationale that the high rejection rate in the physical examinations of draftees was connected to the lack of pregnancy care in the earlier generation.[35] Odin Anderson has mentioned that the Act was "the first national health services program for a conspicuous segment of the population. Congress felt it could do nothing less for our soldiers."[36]

As another emergent measure to aid the increasing number of men in the armed forces, the federal government expanded medical service for veterans. In early 1941, Brigadier General Frank Hines emphasized the critical role of health care services for veterans in the face of the uncertain situations abroad. He wrote that adequate care for veterans was "not only an essential part of national defense" but also "a definite obligation which we as a nation should never fail."[37] Learning from World War I, he suggested planning an expansion of veterans' medical facilities and personnel in order to prepare for the coming war. Already in 1937, the Veterans Administration began a ten-year plan to add one hundred thousand beds, but the war hastened the progress of the plan; the goal was reached by the end of 1942.[38] As the war required more men in the armed

forces, the number of potential beneficiaries rose; the number of physicians who were publicly employed increased; and the federal government expanded the construction of veterans' hospitals.

Farmers also were seen as an important group for war mobilization. The Farm Security Administration (FSA) had been promoting the formation of medical cooperatives in rural areas. Recognizing that the poor health of farmers led to a higher rejection rate—about 50%—among draftees from rural areas than from other areas, the FSA began to operate experimental health programs in 1942. The programs were significantly different from previous FSA medical programs. The new programs included all farmers, whereas the previous ones included only low-income farmers. In addition, the new program offered both direct subsidies and loans to individual farmers to encourage enrollment in prepayment plans, while the previous programs had offered only loans. Furthermore, the new program provided more comprehensive care than the previous ones. In 1942, the medical cooperatives covered about 115,000 farm families in forty-three states. Thomas Clark has noted that the FSA officials foresaw during the war that the establishment of the experimental programs, combined with the existing programs, would lead to more radical national health care reform.[39]

The AMA made case-by-case responses to these developments of health insurance. An editorial in the *Journal of the American Medical Association* (*JAMA*) noted that some state-level medical societies were warning of dangers connected with the EMIC. The Michigan State Medical Society, for example, worried that the program would "encourage the development of a poor quality of obstetric and pediatric care, establish a precedent for further extension of governmental interest into the private practice of medicine . . . and open the door to governmental medical service for all, without economic distinction or determination of need and establish a fee-schedule."[40] The AMA, however, presented general support for the FSA-led medical cooperatives in rural areas. In 1942, a survey showed that four out of five doctors who participated in the FSA programs had a favorable opinion of them, perhaps because most medical societies had the right to vote to renew the annual contract.[41] Finally, in *JAMA*, especially at the beginning of the war, the AMA refrained from hostile comments on the expansion of health service for veterans, most likely because it felt that the public might perceive such sentiments as unpatriotic.

In addition to the publicly administered or assisted programs offering care for families of servicemen, veterans, and farmers, private health insurance for workers expanded as the mobilization deepened. Coverage by private health in-

surance plans increased from 9.3% in 1941 to 24% in 1945. Among them, Blue Cross and Blue Shield plans increased their membership from 6.4% of the population in 1941 to 14.2% in 1945.[42] The federal government played a role in this increase in private health insurance because of its concern about the war economy. As the war advanced, the federal government was worried about inflation. In July 1942, as an anti-inflation policy, the government adopted the "Little Steel formula." The name for this formula was inspired by the War Labor Board's rule allowing workers in four steel companies to increase wages based strictly on rises in the inflation rate between January 1, 1941, and May 1, 1942.[43] Because employers could not increase wages to attract workers, they more often used private health insurance as a fringe benefit.[44] The Revenue Act of 1942, furthermore, allowed full tax deduction of employers' health insurance costs as a fringe benefit. It helped companies that suffered from a heavy tax burden and further extended private health insurance.[45]

Helen Baker and Dorothy Dahl have argued that many factors contributed to the expansion of private health insurance during the war, but "probably the most important of these was the governmental wage stabilization policy."[46] To this argument, Frank R. Dobbin has replied, "Instead, it appears that public policy changes such as Wagner Act and Social Security led to union and business support for private insurance, which in turn spurred the growth of fringe benefits."[47] These arguments, however, should complement each other. Previous labor legislation helped organized labor and business leaders to take advantage of fringe benefits at the negotiation table. But the government's anti-inflation policy and wartime economy made many more of them realize that the alternative actually worked well for both.

While private plans that hospitals and doctors administered increased, private firms initiated other types of private plans. During the war, some employers decided to provide more comprehensive health services to their workers, especially in places where the migration into war industries was substantial, such as the west coast. Henry J. Kaiser, for example, created prepayment health insurance and hired salaried medical professionals to provide his workers with access to medical and hospital services.[48] Although Kaiser's health plan competed directly with individual practitioners because his plan set fees and hired doctors as a group, as a "war baby" it could expand.[49]

The AMA was perplexed about the rise of private health insurance. Before the war, the AMA accepted only private health insurance programs that were based on the cash indemnity principle, which meant that patients got paid the same amount of money no matter what medical care they received. The

AMA still wavered in its judgment about whether it as an organization would benefit from theoretically more physician-friendly Blue Shield plans. Even after the AMA established a committee to coordinate Blue Shield plans in 1943, Paul Starr has noted, the AMA leaders did not seriously promote the expansion of Blue Shield plans.[50] Furthermore, the AMA continued its opposition to private plans sold by for-profit insurance companies. It was only after the war that the AMA aggressively pushed for private health insurance as an alternative to national health insurance.

While public health insurance for select groups and private health insurance expanded, reformers pushed for universal health insurance in connection with war mobilization. As early as July 1940, Michael Davis, a prominent advocate of public health insurance and the chairman of the Committee on Research in Medical Economics, said, "Entirely aside from the humanitarian aspect, the prevention of disease and the care of illness among the workers in the defense industries are clearly the concern of the government as a measure of efficiency."[51] "I urge that the federal government," he continued, "through the Council on National Defense or otherwise, give public expression to the broad principle that the conservation and care of health is part of the national defense program."[52] Davis asked Isidore Falk, director of the Social Security Board's Bureau of Research and Statistics, if "Senator [Robert] Wagner would be interested enough to write on the needs for adequate health service and medical care for defense workers and suggest the lines of policy which should be followed in developing the service?"[53] Davis called for federal action to promote health insurance in connection with national defense.

In his speech at the National Institute of Health on October 1, 1940, more than a year before Pearl Harbor, Roosevelt also affirmed the link between defense and the health of the nation: "We cannot be a strong nation unless we are a healthy nation. . . . Today the need for the conservation of health and physical fitness is greater than at any time in the nation's history."[54] Keeping in mind potential opposition from the AMA, Roosevelt made it clear in the speech that his intention was not to create "socialized medicine." Although he had not presented a concrete proposal, his statement suggested that it was critical for the United States to improve the health of its population in order to win the coming war.

Meanwhile, media sources took up the shocking news about the health of enlisted men. In August 1940, the *New York Times* warned that nearly one-third of those who had volunteered for military service at the recruiting office on

Whitehall Street in New York were physically unfit.[55] In addition, it showed that in November 1940 one-fourth of draftees in New York City failed to meet the physical requirements for the Army.[56] In January 1941 the federal government announced that it expected that one-third of the inducted men would be returned home because of physical defects, which meant that 1,200,000 men would have to be called to meet the quota of 800,000.[57]

In 1941, the reformers strengthened their drive for national action in health care. In April 1941, Arthur J. Altmeyer, a well-known advocate in the federal government for public health insurance, confirmed that health care programs were important for national defense: "We know that the strength of a nation is only as strong as the fabric of its national morale. In peace, America needs a healthier nation, the facilities and the opportunities for adequate medical care made available to every person; in defense or war, a vigorous health program becomes a pressing and inescapable necessity."[58] When Roosevelt declared an unlimited national emergency in May 1941, the federal government was urged to prepare for a rapid increase in mobilization.

The opponents of national health insurance began to worry that the increasing war mobilization would provide an opportunity for the government to make radical interventions in health insurance. Olin West, secretary and general manager of the AMA, warned Paul McNutt in a letter on July 27, 1941, that the AMA had been informed that "the Social Security Department [Social Security Administration] is as fully convinced as ever of the need of an extensive federal health program, and that Social Security officials believe that such a program, including compulsory health insurance, can now be introduced as a defense measure without special Congressional action." West cautioned McNutt that if such a plan existed, "the medical profession is entitled to have definite information about it from official sources."[59] This complaint showed that the AMA was well aware of the ongoing movement to expand the government's role in health insurance by linking it with war planning.

In his response to West, McNutt wrote, "I can say that such a statement has absolutely no basis in fact."[60] Despite McNutt's denial, however, the movement for national health insurance continued. In July 1941, William Green, president of the American Federation of Labor, sent a letter to Representative John Tolan, Chairman of the House Committee Investigating National Defense Migration, to express the AFL's support for integrating existing social security measures in a single pooled fund that would provide for hospitalization and medical care insurance. He wrote, "In the midst of waging war, Britain has found it desirable

to enlarge and improve its program of social insurance. . . . Our road to a healthier, stronger nation with unshakable morale lies through building greater security for our people."[61] The *Social Security Annual Report of 1941* also concluded that "measures to assure adequate medical care to all persons who need it and to protect workers and their families against the costs of medical care are of basic importance to social and national security and that a beginning should be made in this field."[62]

In October 1941, the president expressed his concern about the rejection rate in physical examinations, which had increased by 10% since July of that year. Roosevelt cast doubt on the theory that the Army's standards for draftees were too high and insisted that the standards were lower than normal, for both the Army and the Navy. The result was "so disturbing that he had asked for a recheck."[63] Right before Pearl Harbor, the president suggested that the federal government take action to solve the problem.[64]

By the end of 1941, the federal government's war preparation had led it to realize that policies to improve the people's health were necessary for national defense. Then the attack on Pearl Harbor occurred, and the subsequent American entry into the war provided a greater justification for the reformers. Three factors encouraged the federal government to intervene in health insurance. First, as the entry into the war boosted the mobilization rate, the rejection problem of draftees became a reality that had to be faced. Second, war mobilization caused a large relocation of people, usually the healthiest ones, into the armed forces, and the government needed to deal with the health of the replacement industrial workers necessary to create a more efficient behind-the-gun economic system. Finally, and most importantly, in facing a national crisis, the federal government could have more authority for intervening in the economy and society, including health insurance.

As war mobilization increased, the rejection rate problem became more serious. As Figure 4.2 shows, the rejection rate for military recruits did not improve after 1942 (the rate was deceptively good at the beginning of 1942 because the government temporarily lowered the age of draftees).[65] The Selective Service System first sought to reduce rejections by further lowering the standards for the physical examination of draftees.[66] But that was not an effective measure. At the end of 1943, the rate rose to its highest level—43.7%.[67] In response to the increasing rejection rate, there was furious discussion about whether men who had become fathers before Pearl Harbor should be inducted in 1943. The controversy led to the appointment of a committee of five physicians to determine whether the military should lower physical standards to meet the country's

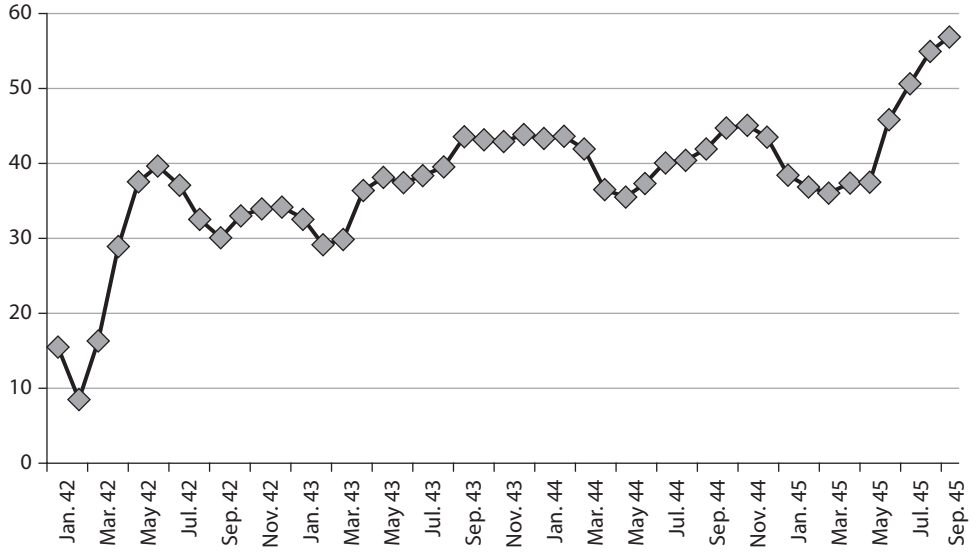

Figure 4.2. Physical Examination Rejection Rate of the United States, 1942–1945.
Sources: *Selective Service System, Selective Service as the Tide of War Turns,* 173; and Selective Service System, *Selective Service and Victory,* 667–68.

manpower needs. They concluded that further reduction in the standards should be avoided but that to lower the physical standard would not drastically decrease the rejection rate.[68]

To Roosevelt, the rejection problem was an "indictment of America."[69] Furthermore, to Brigadier General Lewis B. Hershey, director of the Selective Service System, the problem was "a condition of which we nationally should be thoroughly ashamed. . . . That our physical standards are higher [than previous generations] now, let us admit. Nevertheless, the test of national health is the physical and mental well-being of the people rather than their average length of life. The test of a machine is not merely how long it lasts before it stops entirely, but how well it runs."[70] Thus, the health of draftees, mostly of young men, became a critical issue for maintaining national morale and making an efficient mobilization.

In addition to the rejection problem, the sickness rate among workers attracted the attention of those responsible for the government's war mobilization efforts. As Table 4.1 shows, the manpower supply tightened drastically in 1942. Demand for manpower in the war economy and the armed forces led to the absorption of existing human resources. By the end of 1943, the war economy reduced the number of the unemployed to one million. Responding to the

near-exhaustion of existing manpower, government officials sought to reduce the effects of sickness on labor productivity to improve the war economy.

Even before that, Thomas Parran pointed out in an address in a meeting held by the AMA that 350 million man-days were lost in 1940 due to illness and accidents among industrial workers, which meant that the United States had lost the manpower of one million working men.[71] The U.S. Public Health Service also reported a trend of deteriorating health as war mobilization increased. In 1940, the rate of sickness for industrial workers was 96 per thousand male workers and 153 per thousand female workers, but in 1941 it was 101.3 and 163.3, respectively.[72] In 1941, discussing the deteriorating health of workers, Parran warned that the loss of working days would "build twelve cantonments of average size, or five battleships, or 16,407 combat tanks."[73] Isidore S. Falk noted that the low standard of workers' health resulted from the financial barriers to accessing medical care. Although the war economy had increased workers' earnings, according to Falk, the increases did not compensate for the rising cost of living.[74]

Falk also stressed that the health of workers was critical for fighting the war by noting that "national security has become gravely endangered and our economic patterns are now being strained in unprecedented ways by the forces of war. Old health problems have developed new dimensions."[75] He warned that deeper mobilization would make the health issue more serious because "industrial health and medical needs will probably take on increasing importance as the further expansion of the labor force for war production becomes both more difficult and more urgent."[76] Moreover, as Wilbur Cohen, technical adviser to the chairman of the Social Security Board, concluded, "It is imperative that we quicken the tempo of social progress so that our social services may meet our increasingly urgent needs. . . . It is increasingly clear that an expanded social security program is as necessary to victory as is production of guns and ships."[77] These voices showed that the health of civilians, especially of industrial workers, was on the minds of national security policy makers.

In May 1942, a correspondence between Kingsley Roberts and Hugh Cabot was circulated by Davis to Altmeyer and Falk in the Social Security Administration. The correspondence showed that major advocates of national health insurance realized that the war had offered them a chance to introduce radical reform in health care. Kingsley argued that doctors' experiences under military medicine might lead them to adopt more group practices because of the loss of their individual practices at home and that former servicemen might call for

something close to military group medical practice after the war. Second, the AMA's influence on the social security policymaking process might become weaker in a national emergency, as had been seen in the case of the relationship between the AMA and the PHS. Third, doctors left in civilian practice might encourage one another to form group practices around hospitals and health service centers in order to assure good care. As a result of these challenges, Kingsley claimed the war would bring about some modification in the current medical system and listed things that might happen:

> The government might intervene and pass legislation providing for:
> (a) prepayment medical care plans for Social Security clients
> or (b) prepayment plans for hospital service for Social Security clients
> or (c) prepayment plans for Social Security including both (a) and (b)
> or (d) a tax-maintained system to provide all health services and medical care for all people in the country.[78]

Although Roberts did not claim a direct relationship between the intensity and length of the war mobilization and the predicted reforms in health care, his argument implied that the more devastating and longer the war, the more the AMA's power would diminish and the more likely it was that radical reform would occur. He noted, "The AMA influences on the Social Security program, the Selective Service System, rehabilitation, procurement and assignment, regular army and navy organizations, may break down. The USPHS [PHS] is already nearly out of their control and they have lost Social Security entirely because they were not realistic about changes occurring in the social thinking in government departments."[79] This correspondence showed that at the beginning of the war, major advocates of national health insurance recognized the possible impact of war mobilization on the medical system: specifically, it would diminish the political power of the AMA and push for health insurance reform.

In late 1942, the release of the Beveridge Plan in Great Britain encouraged the advocates for national health insurance in the United States. Cohen took a "tremendous interest" in the Beveridge Plan, and he had it rendered in American English to "help make the report intelligible to them [the newspaper men]."[80] In January 1943, the *Social Security Bulletin,* the official monthly report of the Social Security Board, included a summary of the Beveridge Plan. It clearly argued that the war would be a great opportunity to cause changes "which will be acceptable to all but which would have been difficult to make at other times."[81] The British effort to maintain morale and solidarity for the war and to prepare for

postwar reconstruction provided the reformers with a clear reason to convince people that the United States needed an "American Beveridge Plan."[82]

As "an American answer to the Beveridge Plan," Senator Robert Wagner submitted to the Senate a bill with Senator James Murray (D-Montana) on June 3, 1943, and Representative John Dingell (D-Michigan) submitted it to the House.[83] The bills were popularly called the Wagner-Murray-Dingell (WMD) bill. The bills had their origin in the group of advocates of public health insurance in the Roosevelt administration. In early 1942, Altmeyer asked Cohen to write a memo on national health insurance. The inquiry was transferred to Falk, and he and his staff drafted the bill.[84] Falk gathered the information about the health of the nation, including the rejection problems among draftees and private health insurance. Falk and Cohen approached Senator Wagner with their study in December 1942.[85]

The WMD bill of 1943 was an omnibus bill and called for a "cradle-to-grave" social insurance plan. The WMD bill included amendments to various social security programs such as an unemployment insurance system, an old-age pension, and aids to the poor. However, the core of the bill was a proposal for the creation of a new program that would offer comprehensive, national, prepaid health insurance for workers and their dependents.[86]

The prepaid health insurance plan suggested more centralized control by the federal government than did the Wagner bill of 1939. While the Wagner bill aimed at providing grants-in-aid for the state governments to use in health insurance plans, the WMD bill proposed that national heath insurance be administered as part of the Social Security Program and offer medical and hospital benefits to almost all workers and their dependents.[87] The bill also proposed the central role of the surgeon general of the Public Health Service in setting the payment method for national health insurance. The surgeon general was to be the chairman of a National Advisory Medical and Hospital Council, which would consist of sixteen members appointed by him.

In the formative stage of the bill, Senator Murray emphasized the relationship between the war and social security policy. He commented, "We are in the middle of the most devastating war ever inflicted on the human race. Victory in this struggle must bring with it a larger measure of security for our people than ever before."[88] Monte Poen has also indicated that this proposal incorporated the spirit of Wagner's 1944 statement that "we cannot win the peace with forty-eight separate economic programs, for our whole economic system is one and indivisible."[89]

Public opinion was favorable to the WMD bill. According to *Fortune* magazine, 74.3% of Americans were in favor of national health insurance in 1942.[90] A Gallup poll asked in 1943, "At present the Social Security program provides benefits for old age, death and unemployment. Would you favor changing the program to include payment of benefits for sickness, disability, doctors and hospital bills?" Fifty-nine percent answered yes; 29% answered no. The poll also asked if people would be willing to pay 6% of their income to make this program possible; 80% of people were willing to pay 6% of their income for the expansion of social security.[91] These polls showed that by the end of 1943, the movement for national health insurance had widespread support.

The demands of war led first to the establishment of public health insurance for selected groups and the rise of private health insurance. With deepening mobilization, furthermore, reformers intensified the movement for the creation of a more centralized and larger public program. The WMD bill, however, never got out of congressional committees. Why did the WMD bill fail to pass during the war?

Scholars who focus on the political system would explain that Congress still had strong power to check the President's authority and that the conservative coalition between the Southern Democrats and Republicans blocked the passage of the WMD bill. One might also emphasize that in contrast to its Japanese counterpart, the AMA maintained its independence from the government. But this chapter suggests that there are two other reasons. First, because the United States suddenly got involved in full mobilization, it had to deal with two fronts at the same time: responding to urgent needs—such as creating the EMIC and promoting private health insurance—as well as planning a larger public health insurance program. If there had been a preceding steady mobilization period in which the government had produced moderate reforms and made a preparation for larger reform, the government would possibly have had more opportunity to make a radical reform.

Second, the period when the government projected a rapid increase of mobilization for an uncertain period did not last long enough to turn the government's policy preferences into policy outcomes. Soon after the WMD bill was proposed as part of the national security policy, the war mobilization stopped increasing. The next section shows that after it reached the peak of mobilization, the United States ended up with a moderate reform in health insurance despite the many voices for radical reform.

ACHIEVING MODERATE REFORM, JANUARY 1944–AUGUST 1945

Nobody was clear about when and how the war would end when the Wagner-Murray-Dingell bill was introduced in June 1943. All that was known was that the federal government was urged to meet the increasing manpower demand. By the end of 1943, however, it became clear that the war mobilization would stop radically increasing. In Europe, the Soviet Union continued the counterattack against Germany after it won the Battle of Stalingrad in February 1943. In the Pacific, Japan lost the Battle of Midway in June 1942 and began to withdraw from Guadalcanal in February 1943. These events led the United States to shift its war strategy from defensive to offensive, and by the end of 1943, the United States began serious preparation for postwar reconstruction. This change in the progress of the war influenced the power of the federal government and what it sought to do in the field of health insurance.

The Government's Power in Steady War Mobilization

There was a fear in early 1943 that the United States would face a devastating shortage of manpower in 1944 if the war were to continue at the same level of intensity. At the end of 1943, however, the overall mobilization situation had been stabilized, and soon the pressure to increase manpower eased, although the level of mobilization remained high.[92] In December 1943, as industry experienced a net loss of workers for the first time since the start of the war, the government and the public began to shift their concern from the war battles to postwar reconstruction.[93] In February 1944, moreover, Lawrence A. Appley, deputy chairman and executive director of the War Manpower Commission, admitted that the steep increase in war mobilization had come to an end.[94] In May, the Selective Service System ordered deferrals for most men from age 26 to 39 for at least six months and for older men indefinitely.[95] The federal government was now past the crying need for more manpower.

When the United States succeeded in the Normandy Campaign in June of 1944, the government was convinced that the war in Europe would not last long. In August 1944, Appley also stated, "All of us sense that and fervently pray that the Nazi collapse will be swift as it is inevitable."[96] Although the conclusion of the fight with Japan was less certain at that moment, the end of the European campaign signified a huge demobilization for the United States. Appley predicted in April 1944 that if Germany fell, the war industry would decrease

production anywhere from 35% to 50%.[97] Federal officials began to focus more on postwar affairs than war mobilization in the "period when an attitude of 'war is about over' became more prevalent than ever among Americans at home."[98]

In 1944 and 1945, the demand for civilian manpower in industrial and agricultural production continued to decline. The job vacancies were filled more adequately from July 1944 to the end of the war than in previous periods.[99] In October 1944, Roosevelt signed a bill to convert the Office of War Mobilization into the Office of War Mobilization and Reconversion, "unifying and coordinating all governmental programs relating to war mobilization and peacetime reconversion."[100] This symbolized the federal government's shift from war mobilization to postwar reconstruction. In these circumstances, the passage of a labor draft that had been debated in 1943 seemed hopeless. In December 1944, Secretary of War Henry Stimson still tried to convince President Roosevelt that government control of the labor market would be necessary to deal with manpower shortages. But a labor draft did not pass, for the simple reason that his claim did not reflect what was actually going on at that time.[101] George Flynn summarized the political situation of 1944 as follows: "Majority opinion in 1944 supported fewer controls rather than more restrictions. To an increasing number of citizens the war appeared already won. The question now concerning many people was how the end of the war would affect their job status. The problem of reconversion to peacetime became an important issue months before the last shot was fired."[102]

In sum, from around the end of 1943 to the summer of 1945, the federal government understood that the end of the war was within sight and that the United States eventually would win the war. The government did not project any further radical increase in armed forces personnel and war industry workers. The government's projections about the war as well as public sentiment about the war constrained the government's power. When the tide of the war was uncertain and war mobilization continued to increase, the federal government had an opportunity to expand its power to do what was necessary for victory. When it became widely accepted that the war would end soon, however, the federal government could not retain its power any more. The next section demonstrates how these political dynamics affected health insurance policies.

Moderate Reform in Health Insurance

President Roosevelt, in his State of the Union address on January 11, 1944, presented the Economic Bill of Rights. Roosevelt had been reluctant to show his

full support for the WMD bill, but the Economic Bill of Rights articulated that he had begun to move toward an endorsement.[103] Roosevelt asserted:

> We have come to a clear realization of the fact that true individual freedom cannot exist without economic security and independence. . . . We have accepted, so to speak, a second Bill of Rights under which a new basis of security and prosperity can be established for all—regardless of station, race, or creed. Among these are. . . . The right to adequate medical care and the opportunity to achieve and enjoy good health.[104]

At the end of this message, he repeated that it would be necessary to pass his policy proposals in connection with the war by noting, "Each and every one of us has a solemn obligation under God to serve this Nation in its most critical hour—to keep this Nation great—to make this Nation greater in a better world."[105] Some government officials saw reconversion to peace as an opportunity to expand the role of the federal government in social policy. They "sought to use reconversion as a means of launching a new ship of reform . . . reconversion would be the last chance to show that the war had been fought for more than a return to the status quo, the sacrifice had been for a brave new world."[106] However, universal health insurance remained beyond their reach. In contrast to the reformers' hope, once it was thought that the war would soon be over, the AMA and its allies came to life again to block the creation of universal health insurance. The only area in which the government had a major achievement in terms of expanding public health insurance was public health care for veterans.

As the war continued, many soldiers began to return home. The government was urged to make arrangements so that returned soldiers could adjust to civilian life. The government and the public still remembered that World War I veterans gathered in Washington, D.C., in 1932 to ask for full payment of the government's compensation for their service in what became known as the Bonus March. To avoid the same mistake, the government took action to produce measures for World War II veterans while the war was still going on. The American Legion, which was the largest veterans' association at that time, took the lead. Harry W. Colmery, a former national commander of the American Legion, played a significant role in making the first draft of the bill, later known as the G.I. Bill of Rights. The bill was introduced in January 1944. When the bill faced gridlock in Congress, the American Legion mobilized its members to back the legislation. As Donald G. Glascoff, national adjutant of the American Legion, wrote after the bill passed, "All the breaks for World War Two veterans guaranteed by the G.I. Bill of Rights didn't 'just happen.' They were made by The Amer-

ican Legion. Legionnaires never forgot those tragic days of demobilization that followed the last war, with the unemployment riots and bonus marches."[107]

On June 22, 1944, the G.I. Bill of Rights, formally called the Servicemen's Readjustment Act, was enacted. The benefits for veterans were intended to improve the morale of soldiers, ease their families' worries, reward their loyalty to the nation, and stabilize the economic and political order for postwar reconstruction. In contrast to the previous VA laws, the G.I. Bill had a huge number of potential beneficiaries. In 1950, five years after the end of the war, the number of veterans reached 19 million people, about 8% of the population, whereas their proportion was less than 0.4% before World War II.[108]

The G.I. Bill of Rights went into effect on October 4, 1944, and it included provisions to provide hospitalization and medical care benefits for veterans who had served for 90 days and were honorably discharged. The G.I. Bill gave the Veterans Administration 500 million dollars in the first year to construct new VA hospitals.[109] The VA hospitals and other public facilities provided the care; if such facilities were not available, private hospitals provided the care with reimbursement by the federal government.[110]

As it had previously operated, the VA health care provided not only outpatient services and hospital services to veterans who had service-related incidents but also hospital services to those who had non-service-related health problems, only "if beds are available and if the veteran [is] unable to pay for such medical care beds."[111] However, the VA health care regulations did not address how it would check whether patients were in financial difficulties. "In practice," an interim report to the Committee on Education and Labor noted, "there has been no definition of ability to pay in terms of the individual's income and no investigation of the patient's economic status."[112] In May 1945, Major Thomas M. Nial wryly observed, "Unless you have quite a number of chips stacked away or a big-paying job, I doubt if you will honestly conclude that you are financially able."[113]

The expansion of the VA health care system did not satisfy advocates of universal health insurance. The movement for universal health insurance continued even after the mobilization stopped increasing in 1944. In January 1945, the Senate Subcommittee on Wartime Health and Education, called the Pepper Commission after the chairman, Claude Pepper (D-Florida), submitted an interim report to support Roosevelt's proposal for the expansion of the social security system, including the creation of national health insurance for workers and their dependents.[114] The interim report was the first congressional committee to back national health insurance; it proposed that the federal government pay for building hospitals and clinics and create some form of health insurance.[115]

When the Pepper Commission was formed, there was intense interest in the subject; as Monte Poen put it, "Health insurance was debated as never before."[116] The *Journal of the American Medical Association* and other publications, such as *United States News,* had articles critical of health care reform. On the other hand, *Collier's* featured an article arguing that the United States needed national health insurance. Furthermore, Michael Davis had a weekly series supporting health care reform in the *Survey Graphic*.[117] The *Washington Post* had been reluctant to throw its support behind wartime health care reform because of the additional contributions of five billion dollars annually from employers and employees. But now the *Post* decided to give strong support to health care reform, commenting that it was needed for a smooth transformation from wartime to the postwar era. An article refuted the AMA's repeated strategy to call national health insurance "socialized medicine" by writing, "If this [national health insurance] is socialism, then so is the public school system. Good health, like good education, is one of the cornerstones of a democratic society."[118] *Fortune* also moved from caution to sympathy. By the summer of 1944, it was going to have an article critical of the WMD bill, but because of efforts by Wagner and Falk, its December 1944 issue had an article that favored their proposal.[119] The health insurance discussion leaned toward comprehensive national health insurance.

To realize the reformers' wish, the Wagner-Murray-Dingell bill was resubmitted in May 1945. But the actions of Roosevelt, the Pepper Commission, media attention, and the WMD bill of 1945 did not result in the creation of a universal health insurance program. Although Roosevelt's death on April 12, 1945, might partially explain this failure, the decline in the war efforts and the belief that the war would soon be over largely contributed to it as well. The change of the war tide resulted in the revival of the opposition groups. By June 1944, for example, the AMA began to intensify the usual allegations about the government's intervention in health insurance. Ernest E. Iron, the secretary of the AMA, said, "Individualism is necessary in dealing with the diverse economic and social conditions in the several portions of this country. . . . Here in America the central thought of our life and development has been freedom of action—free enterprise."[120] Toward the end of the war, the AMA started to claim that the "American Way of Life" had contributed to America's victory in the war. On June 22, 1945, the AMA declared, "American private enterprise has won and is winning the greatest war in the world's history."[121]

On the other hand, the reformers could no longer justify the introduction of national health insurance in connection with the war, because war mobilization had waned and the G.I. Bill of 1945 had established separate public health insur-

ance for veterans.[122] In 1942 and 1943, many articles in the *Annual Report of the Social Security Board* and the *Social Security Bulletin* claimed that national health insurance would help the United States win the war. But no such argument could be found in 1945. In January 1945, instead, the *Social Security Bulletin* reasoned its support for national health insurance by arguing that because the American nation was known as the richest country in the world, it was necessary to make Americans the healthiest in the world as well.[123] But the United States overcame the national crisis challenge, winning World War II without a radical reform of health insurance. Reformers faced difficult questions: Does the United States need to introduce national health insurance just to be the healthiest nation in the world? Any other reasons? Reformers could not find good answers to these questions after the federal government began the demobilization.

The VA health care puzzled reformers. Although the establishment of the G.I. Bill of Rights meant "unprecedented steps in the direction of the welfare state in the immediate postwar era," it retrospectively had a negative effect on the movement for universal health insurance.[124] It symbolically and substantially meant that veterans' health insurance would be considered separately from that of others. Roosevelt sensed this implication and was unenthusiastic about supporting a program specifically for veterans. George Q. Flynn has written, "As with the issue of reconversion, the subject of planning for returning veterans did not attract White House attention. Roosevelt seemed reluctant to cater to the veteran for fear of downplaying the important role of the civilian war worker."[125] One option that the United States could take after the war would be to expand what the federal government had done for veterans to the rest of the population. This was actually the precise dream of some reformers. But that did not happen. No significant expansion of public health insurance took place after the war. Instead, private health insurance continued to increase after the war.

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CHAPTER FIVE

Consolidating the Hybrid Health Insurance System

The United States, 1945–1952

After the war, the United States faced a number of important questions. How should the United States deal with the wartime public health insurance programs, such as the one for veterans? Should the United States try to finish the task that Franklin D. Roosevelt had left: the introduction of universal health insurance? How should the United States cope with the rise of private health insurance?

The advocates of public health insurance sought to introduce universal health insurance. On the other hand, the American Medical Association took actions to abolish the wartime measures and block the introduction of universal health insurance. This chapter demonstrates that the American way of ending the war diminished the power of public health insurance advocates while helping the AMA to achieve its goals. By the end of the 1940s, the basic structure of American health insurance remained the same as the one developed during the war: public programs for select groups and private programs for those who could afford it.

LEGACIES OF WARTIME HEALTH INSURANCE DEVELOPMENTS

World War II expanded both public and private health insurance in the United States. As the previous chapters demonstrate, the government expanded its role in the health care of select groups, such as the spouses and infants of servicemen, farmers, and veterans. The Emergency Maternity and Infant Care program,

however, was discontinued in July 1947 because of its "having served its wartime purpose."[1] Moreover, in 1946 Congress passed legislation to replace the Farm Security Administration with the Farm Home Administration. This transition killed the FSA's health insurance programs for low-income agricultural workers. The AMA and its conservative allies had already begun their opposition to the FSA programs in late 1943 by labeling them the "American equivalent of Stalin's forced collectivization of Soviet agriculture."[2] In contrast to the demise of these two programs, the VA health care and private health insurance continued to grow after the war. Both of them had more institutional, political, and financial support than they had before the war. The wartime legacies—VA health care and private health insurance—shaped the postwar politics of health insurance.

National Responsibility for Veterans' Health Care

Because veterans had risked their lives in the war to protect the nation, nobody denied them some kind of public assistance. The G.I. Bill of Rights of 1944 included funds to expand the VA hospitals. The number of VA hospitals increased from 101 in 1946 to 174 in 1953.[3] The number of veterans under VA hospital or domiciliary care increased from about 71,000 per day in 1945 to 102,000 in 1950.[4] Meanwhile, government expenditures for the construction of VA health care facilities increased about tenfold in five years, from $15,801,000 in 1945 to $151,532,000 in 1950.[5] Veterans seemed to be entitled to receive some public care; however, there was no consensus about which veterans should have benefits and what kind of care they should have.

This debate existed even before World War II. World War I resulted in the expansion of the VA health care. The VA health care initially targeted those who had service-related disabilities, but soon after the end of World War I care was extended to non-service-related problems. Although the Economic Act of 1933 temporally narrowed the kinds of diseases treated and shortened the length of treatment, the 1934 amendment resulted in loosening the 1933 restrictions.[6] The provision included in the 1934 amendment stipulated that veterans were entitled to receive care for any disabilities if they were poor. Whether veterans were poor or not, however, depended not on the government's decision but on the veterans' self-description under oath.[7] The G.I. Bill followed the 1934 regulation about eligibility. Patients who wanted to be treated in VA hospitals were merely confronted with the following question: "Are you financially able to pay the necessary expenses of hospital or domiciliary care. Check Yes or No." If they made the "pauper's oath" by saying no, there were no further investigations.[8]

Before the war ended, however, Congress discussed proposals to eliminate the pauper's oath, making all veterans, whether poor or rich, entitled to public care.[9] President Truman supported this proposal, and he went further, suggesting the same care for veterans' dependents. In his special message to Congress on November 19, 1945, he claimed, "Many millions of our veterans, accustomed in the armed forces to the best of medical and hospital care, will no longer be eligible for such care as a matter of right except for their service-connected disabilities. They deserve continued adequate and comprehensive health service. And their dependents deserve it too."[10] To Congress, which did not make good on Truman's suggestion, he advocated again in February 1946 that the VA health care include as many veterans as possible.[11] Although Truman could not get rid of the pauper's oath, the VA health care retained the de facto policy of treating wealthy veterans with non-service-related disabilities.[12]

Moreover, the relationship between the VA hospitals and other medical providers also contributed to the increase of VA patients with non-service-related incidents. Before World War II, many VA hospitals were located in rural areas and had dismal reputations. But the VA began to build its new hospitals in urban areas and developed close relationships with medical schools in order to stay up to date with the latest medical technology. In exchange, medical schools gained a new resource: workplaces for their residency programs.[13] That residency programs called for a full range of patients for training programs was an incentive for the VA hospitals to accept not only veterans with service-related disabilities but also veterans with non-service-related disabilities.[14]

Truman's efforts and the existing medical structure helped the VA health facilities treat those with non-service-related incidents. The estimates in 1946 and 1952 both suggested that about two-thirds of the patients were getting free care for non-service-related disabilities; in fact, about 34,000 such veterans per day had treatments in the VA facilities in 1952.[15] Because of the large number of World War II veterans, the VA health care became more politically visible in the postwar era than in the antebellum period.

Private Health Insurance

While the VA health care expanded, private health insurance also continued to grow. As described in chapter 4, many employers suffered from a shortage of workers during the war because many healthy workers had been taken to the battlefield. They hoped to increase wages to attract workers; however, the government feared inflation and did not allow the wage increase. Instead, by

changing the tax code, the federal government encouraged firms to offer private health insurance as a fringe benefit to their employees.[16] By 1950, about 95% of employees who joined CIO unions had health insurance plans in their collective bargaining agreements.[17] Moreover, the contents of the private health insurance plans gradually became favorable for employees. Employers, an insurance industry study showed, became more and more generous in contributing to the health insurance costs of their employees: they covered only about 10% of the entire cost in 1945, but by 1950 they were covering 37% for workers and 20% for their dependents.[18]

A 1949 Supreme Court decision also helped to extend private health insurance. There were many employers that still resisted the inclusion of health benefits as part of collective bargaining. The *W. W. Cross & Co. v. National Labor Relations Board* decision upheld that private group health insurance is a legitimate item in negotiations with employees. This decision signified, as Harry Becker put it, "for the first time a firm legal basis for including hospital and medical care programs on the collective bargaining agenda."[19]

In sum, private health insurance coverage began to expand steadily during the war and continued to grow in the postwar period because health insurance became, not only practically but also legally, part of workers' fringe benefits. Private health insurance had become dominant in American lives by the end of the postwar reconstruction: about 24% of the population had benefits deriving in some way from private health insurance programs in 1945, 42% in 1948, and 51% in 1950.[20] The growth of private health insurance became irresistible by 1950.

THE DEFEATED RADICAL REFORM

The growth of the VA health care and private health insurance had a significant impact on the postwar movement for universal health insurance. The VA health care, in a sense, represented the promise of centralized public insurance: it ran public hospitals, set doctors' fees, and offered care to veterans without fees. The system of private health insurance was very much the antithesis of the VA health care: it relied mostly on private hospitals with no government control over doctors' fees or the selection of services provided. The rise of private health insurance and the VA health service changed the postwar politics of health insurance.

Before the war, the AMA resisted the expansion of private health insurance; however, in the postwar political circumstances, the AMA changed its strategy

to aggressively promote private health insurance as an alternative to universal health insurance. Meanwhile, the AMA labeled the VA health care as a vicious—because of red tape and inefficiency—example of public health insurance. When President Harry S Truman and reformers proposed the introduction of universal health insurance, they had to fight the AMA, which had adopted these new strategies.

Truman's Proposal and Revived Opposition, 1945–47

When the postwar period began, the federal government found it difficult to retain its wartime power. The government did not have to restore cities, the economy, and the lives of most Americans, at least not as much as Japan and many other war participants. Therefore, it was politically difficult for the government to achieve a drastic change in health insurance in the name of postwar reconstruction. When Truman pushed for universal health insurance after the war, he had to deal with the new political environment.

Truman embraced health care as one of the most important issues in domestic policy after V-J Day. On September 6, 1945, Truman proposed a twenty-one-point program that updated the Economic Bill of Rights proposed by Roosevelt in January 1945. On November 19, he sent a special message to Congress specifically concerning health care, an unprecedented event in U.S. history.[21] He reiterated one of the most important rights mentioned in the twenty-one-point program: the right to adequate medical care. To achieve it, he recommended a single compulsory health insurance program based on the Social Security Program's financing model. But Truman's health insurance plan sought to go beyond the Social Security Program by proposing to cover those whom the Social Security Program excluded at that time, such as professionals, agricultural workers, and domestic workers.[22] Truman emphasized the inability of private health insurance to accomplish universal coverage: "Voluntary health insurance plans have been expanding during recent years; but their rate of growth does not justify the belief that they will meet more than a fraction of our people's needs." A health fund, Truman continued, "should be built up nationally, in order to establish the broadest and most stable basis for spreading the costs of illness, and to assure adequate financial support for doctors and hospitals everywhere." He also tried to placate his political opponents: "I repeat—what I am recommending is not socialized medicine."[23]

Immediately after his special message to Congress, Truman ordered an institutional reorganization in the area of social welfare. Truman asked Watson

B. Miller, the acting federal security administrator, "to take primary responsibility for legislative measures necessary to carry out the part of my message outlined in Section 21 concerning a national health program."[24] In March 1946, Truman also commanded Miller, now the federal security administrator, "to mobilize all the resources within the Federal Security Agency for vigorous and united action toward achieving public understanding of the need for a National Health Program."[25] Furthermore, in order to integrate health and welfare administration, Truman upgraded the Social Security Board, which had been dealing with health insurance matters, by creating the Social Security Administration.[26] The Children's Bureau was also transferred from the Department of Labor to the Federal Security Agency to integrate health care programs for women and children with those for the rest of the population.

Legislative activities in Congress reflected Truman's enthusiasm. On November 19, 1945, the same day that Truman sent his recommendation for a comprehensive health program, the Wagner-Murray-Dingell bill was introduced again. This time, unlike the WMD bill of 1943, it did not overhaul the social security program but reformed health care policy specifically. The 1945 bill also emphasized that medical care would be comprehensive, "including not only general practitioner services, but also specialist and consultant services, necessary laboratory services, dental care, expensive medicine and appliances, hospitalization and home nursing."[27] The proposal estimated that between 75% and 80% of the population would be covered by the proposed program. The bill also included a provision for use of nonprofit consumer-sponsored medical cooperatives, but not ones under the control of the medical associations.[28] Lastly, it proposed that administrative power belong to the surgeon general, and that the National Advisory Medical Policy Council be established to coordinate the interests of the medical professions and the public.[29]

Despite his will to set health reform as one of his administration's top priorities, Truman's rationale for reform was not convincing. He continued to draw on wartime rhetoric to justify the need for the United States to have universal health insurance. For example, Truman stated in a special message to Congress in 1947, "By preventing illness, by assuring access to needed community and personal health services, by promoting medical research, and by protecting our people against the loss caused by sickness, we shall strengthen our national health, our national defense, and our economic productivity."[30] However, this justification encountered two difficulties. First, it was hard to convince the public that universal health insurance was necessary for national defense, even in the shadow of the Cold War, after the United States won World War II.

Second, with soldiers returning to civilian life, concerns about the loss of economic productivity due to sickness did not have as much appeal as during the war because the United States faced not a productivity problem but an unemployment problem in the postwar period. Policy concerned with employment gained more government attention than health insurance policy.

In contrast, the opponents of national health insurance took advantage of the postwar circumstances. For example, Morris Fishbein, editor of The *Journal of the American Medical Association,* countered Truman's rhetoric by praising the existing health care system for helping the United States win the war: "The great victories won by American troops all over the world," continued Fishbein, "were not won by weaklings. The American soldier proved himself to be a competent fighter. He represented a selection of the best physical specimens that our nation had developed."[31] Fishbein also stressed that the health of the ordinary people was not as bad as reformers claimed, saying, "Despite shortages in trained personnel, medicine has been able to carry on for our civilian population at the same highly efficient level as that established for the armed forces."[32]

The AMA condemned the WMD bill as an "attempt to enslave medicine as the first among the professions, industries, and trades to be socialized."[33] It also characterized the Physicians' Forum, a group of reform-minded doctors that had some sympathy with Truman's proposal, as pro-communist. In 1946, the AMA also presented a ten-point program to promote a health insurance plan that relied on private professionals and voluntary private prepayment plans.[34] As Alan Derickson has noted, "The wartime growth of the private health programs, especially the Blue Cross hospitalization plans, gave conservatives hope for a constructive alternative to state intervention."[35] The Surgical-Medical Supply Committee, which represented the interests of pharmaceutical companies, also launched personal attacks against Senator Robert Wagner by claiming that proposals for socialized medicine were sponsored by an "alien" lawmaker who "did not even speak English until he was more than 12," although this allegation was not true.[36]

Robert Taft (R-Ohio) joined in the fight against Truman's health care plan. He interrupted Senator James Murray's opening statement on the WMD bill in the Senate Committee on Labor and Public Welfare, charging that the WMD bill was "the most socialistic measure that this Congress has ever had before it, seriously."[37] He said, "I am not going to attend any more meetings of your committee. We are through, and I think that every one will know that the report of this committee under your chairmanship will be a partisan report which can

command no support or no respect."[38] He left the committee room and did not come back for further discussion under Murray's chairmanship.

The result of the midterm election in 1946 encouraged opponents of Truman's proposal. Republicans became the majority in both the Senate and the House of Representatives. They had their largest victory in a congressional midterm election since 1894, gaining 13 seats in the Senate and 55 seats in the House of Representatives.[39] This was a reflection of the postwar political mood: a call for a return to normalcy. Using the slogan, "Had Enough?" during the campaign, the Republicans took control of Congress for the first time since 1930.[40] Truman himself and his health insurance agenda were unpopular during the election campaign period. Democratic candidates refused to use Truman's name in their campaigns, and he was seen as "an inept and temporary occupant of 1600 Pennsylvania Avenue."[41] The Democratic Party, therefore, did not include health insurance in its national campaign platform.[42] After the election, Charles-Edward Amory Winslow, professor of public health at Yale School of Medicine and an advocate for national health insurance, wrote to Isidore S. Falk, "I have given a great deal of thought to the situation and I think every week which passes makes it more clear that nothing can be expected of a constructive nature from the next Congress."[43]

Most labor organizations shared Winslow's disappointment, but they could not wait for the government to introduce a radical reform. The government's failed attempt convinced more labor organizations to use private health insurance as fringe benefits for attracting members.[44] As CIO leader Walter Reuther said, labor unions had no choice but to promote private health insurance, because "there is no evidence to encourage the belief that we may look to Congress for relief."[45] "Paradoxically," Alan Derickson has written, "even as they pressed their ill-fated campaign for social insurance, unions negotiated thousands of private health insurance programs."[46] The congressional election in 1946 had a large influence on this trend, and it was the "turning point in industrial union policy on health care financing."[47]

In May 1947, Truman sent the Republican Congress his second message on health care, and Congress received the Wagner-Murray-Dingell bill (S. 1320) on the same day.[48] Truman stated, "Healthy citizens constitute our greatest national resource. In time of peace, as in time of war, our ultimate strength stems from the vigor of our people. . . . National health insurance is the most effective single way to meet the Nation's health needs."[49] The centerpiece of S. 1320 was again a system of national health insurance financed by payroll taxes.

To re-energize his efforts, Truman in August 1947 replaced Watson Miller with Oscar R. Ewing for the position of the federal security administrator.[50]

Ewing, an "outspoken supporter of government-sponsored health insurance," advocated the introduction of universal health insurance.[51] He presented a report, "The Nation's Health—A Ten-Year Program," which became known as the Ewing Report, to push for an increase in medical manpower and facilities and the establishment of universal health insurance. The 186-page report, which was endorsed by Truman, was distributed to state and local public health departments, state medical societies, delegates to the National Health Assembly, and other voluntary associations in health care fields.[52]

Truman's actions instigated a counterattack by his opponents. The opponents worked earnestly to discredit the movement for universal health insurance by any means. According to Monte Poen, for example, "With the 1948 presidential campaign just over the horizon, GOP leaders reasoned that their political cause could best be served by conducting an aggressive congressional probe into the Truman administration's health insurance promotion."[53] Taft, chairman of the Senate Labor and Public Welfare Committee, began hearings on S. 1320. With Republicans in control of both chambers of Congress for the first time in sixteen years, GOP leaders could use the hearings to investigate allegedly improper lobbying for national health insurance by the Truman administration.

Some Republicans made a serious effort to use the hearings to paint the Truman administration as a haven for communists who wished to introduce "socialized" medicine in the United States. Leading the investigation into the Truman administration was the House Subcommittee on Government Publicity and Propaganda of the Committee on Expenditures in Executive Departments. The subcommittee, led by Representative Forest A. Harness (R-Indiana), alleged that some reformers had illegally used federal money to promote universal health insurance, claiming that "at least six agencies in the executive branch are using Government funds in an improper manner for propaganda activities supporting compulsory national health insurance, or what certain witnesses and authors of propaganda refer to as socialized medicine, in the United States. . . . 1) The United States Public Health Service; 2) The Children's Bureau; 3) The Office of Education; 4) The United States Employment Service; 5) The Department of Agriculture; and 6) The Bureau of Research and Statistics, Social Security Board."[54]

The subcommittee's final report read, "American communism holds this [health] program as a cardinal point in its objectives; and that, in some instances, known Communists and fellow travelers within the Federal Agencies are at work diligently with Federal funds in furtherance of the Moscow party line in this regard."[55] Harness particularly tried to discredit the Bureau of Research

and Statistics of the Social Security Administration, which was headed by Falk, "the foremost advocate of a compulsory government program."[56] He pointed out that Falk had sent one of his staff members, Jacob Fisher, to New Zealand at government expense to publish an "extremely biased" report on national health insurance.[57] Moreover, Harness, along with the AMA, charged that Surgeon General Thomas Parran had exerted "'extra-ordinary executive pressure' on public health officers in order to assure their promotion of national health insurance."[58] Harness sent a memorandum to Attorney General Thomas C. Clark to request "consideration and appropriate action."[59] The *Journal of the American Medical Association* immediately reported the Harness Committee's accusations in its editorial.[60]

Aiding Harness's assault on reformers and the effort to discredit them was Marjorie Shearon, a former social policy analyst who had worked for Falk at the Federal Security Agency.[61] After a dispute with Falk over the content of an agency report, Shearon resigned and became a central figure in the effort to oppose government health insurance and, in particular, to damage the reputation of Falk, Wilbur Cohen, and other reform proponents.[62] Shearon's *Blueprint for the Nationalization of Medicine,* published in January 1947, described a vast conspiracy of "collaborationists, fellow-travelers, appeasers, satellites and gullible accepters" supposedly headed by Falk, that permeated the Truman administration.[63] Shearon also enjoyed close contacts with Taft and other prominent Republicans, including Senator Forrest Donnell (R-Missouri), who directed the questioning of Truman officials during the Senate hearings on health insurance in 1946 and 1947. Although the FSA's Board of Inquiry on Employee Loyalty dismissed the Harness Committee's charge after an FBI investigation, "Medical McCarthyism" promoted by the AMA and its allies in Congress was a potent weapon against national health insurance.[64]

Concerning the bill itself, the AMA concluded, "In broad outline, the new bill does not depart from the philosophy of the earlier bill and retains the compulsory features that characterized its predecessor."[65] The National Physicians Committee, the AMA's political advocacy branch, was a top spender among lobbying groups to oppose national health insurance: it spent $208,000 in 1946, $389,000 in 1947, and $592,000 in 1948 for advertising, printing, and postage. About one-third of these funds came from large drug companies.[66] Facing the strengthening movement by the opponents, Ewing concluded in 1948, "There is no chance of getting a [health] bill through this year."[67]

Good-Bye to Truman's Dream, 1948–52

When Truman proposed his health care plan, he had to struggle in the postwar political circumstances in which the federal government had difficulties in justifying further expansion of its authority. The elections in 1948 that resulted not only in Truman's victory but also in Democratic majorities in both houses of Congress encouraged some national health insurance advocates. But they did not bring Truman universal health insurance; rather, the victory ironically resulted in a stronger opposition and further expansion of private health insurance. The two wartime policy developments, the VA health care and private health insurance, became the weapons for the opposing groups. The AMA took a two-front strategy to kill the movement for universal health insurance. The first front was to promote private health insurance as an alternative to national health insurance. The other was to criticize the VA health care as a bad example of a public program. With the AMA's success on both fronts, the United States consolidated the hybrid health insurance system: public insurance for select groups and voluntary private insurance for the rest of the population.

Some supporters of universal health insurance believed that the 1948 election offered another opportunity for reform. Reformers such as Ewing, Altmeyer, and Senator Murray felt that they had a "green light" from voters. Altmeyer wrote that "his [Truman's] election, and the election of a Democratic Congress, constituted something of a mandate for Social Security Legislation."[68] Despite Truman's and his party's victory in both houses in 1948, however, the newly elected Democrats in Congress were more conservative. The 1948 congressional election, therefore, led to a stronger conservative coalition between Republicans and conservative, mostly southern, Democrats in key congressional committees to block Truman's liberal reforms.[69]

Moreover, Truman's victory stimulated the AMA to put an end to the movement for universal health insurance. When Truman won the presidential election, the AMA warned its members that "Armageddon had come"[70] and collected an additional 25 dollars (the average income at that time was $1,320)[71] from each member for its "war with Truman."[72] The AMA, furthermore, hired the public relations firm Whitaker and Baxter to conduct a "national education campaign" against the WMD bill through the media, distribution of pamphlets, and expressions of support from other organizations.[73] Whitaker and Baxter, for example, distributed one million copies of a pamphlet entitled "Compulsory Health Insurance—Political Medicine—Is Bad Medicine for America!" They were placed in physicians waiting rooms across the country.[74]

The AMA outspent their opponents. It had a much larger budget, 1.5 million dollars in 1949, than the Committee for the Nation's Health, a prominent group supporting national health insurance headed by Michael M. Davis, which had a budget of approximately one hundred thousand dollars. In fact, the lobbying efforts Whitaker and Baxter undertook were the most expensive in U.S. history at that time.[75]

More important than its public campaign activities was Whitaker and Baxter's recommendation to change the AMA's stance toward private health insurance. The AMA had been hostile or cautious toward any for-profit private health insurance and had been cautious even about nonprofit health insurance, including Blue Shield plans administered by local medical associations. But on Whitaker and Baxter's suggestion, the AMA clearly changed its attitude to support any type of private health insurance. Whitaker and Baxter had worked for the California Medical Association when Governor Earl Warren proposed the introduction of a statewide compulsory health insurance program in 1945. Whitaker and Baxter suggested that the CMA promote private health with the slogan, "You can't beat something with nothing."[76] They made the same suggestion to the AMA. In February 1949, they wrote to the AMA, "We want everybody in the health insurance field selling insurance as he never sold before."[77] Whitaker and Baxter concluded, "If we can get ten million more people insured in the next year and ten million more in the next year, the threat of socialized medicine in this country will be over."[78] With Whitaker and Baxter's suggestion, the AMA shifted its strategy from a hostile or cautious approach to private health insurance into aggressive promotion as an alternative to public health insurance.

While it promoted private health insurance, the AMA spent over $2.25 million to influence the midterm election of 1950. The physicians were alerted in May that "if twenty more radical Congressmen and five or six radical Senators are elected this fall, the fight will be over and we will have socialized medicine."[79] The AMA's campaign succeeded. Symbolically, Senator Claude Pepper (D-Florida), who had been an advocate for public health insurance, lost his primary race. The AMA worked hard to make this happen. The election also brought eight new senators who opposed public health insurance, and Congress no longer felt any urgency to deal with the creation of universal health insurance.[80]

Aware of the AMA's strong power, in 1952 the *New York Times* noted that "the AMA is the only organization in the country that could marshal 140 votes in Congress between sundown Friday night and noon on Monday. Performances of this sort have led some to describe the AMA lobby as the most powerful in the country."[81] The *Yale Law Journal* also pointed out that the AMA not

only was a financially strong organization but also had succeeded in making a coalition with other interest groups, including groups of dentists, nurses, hospitals, social workers, pharmaceutical firms, and insurance companies.[82] It wrote, "Organized medicine also attempts to demonstrate numerical support for its position by getting outside groups to 'go on record' as allies."[83]

Seeing that the proposals for universal health insurance were going nowhere, the AMA made sure that private health insurance would not threaten private practitioners. Otherwise, as it had learned in the past, private health insurance providers could control the details of care and medical fees. Doctors lobbied the state legislatures to grant regulatory powers to supervise private health insurance through state departments of insurance, with which medical associations often had close ties. By 1950, almost all the states had passed such legislation.[84]

While using private health insurance to kill Truman's plan, the AMA fought on another front to discredit health care service for veterans. When the G.I. Bill of Rights expanded the VA health care, Lawrence Kubie wrote, "No one will doubt that the medical care of veterans is a government responsibility. No one sees in this the spectre of socialized medicine. Nor does anyone protest that it sounds the doom of private practice."[85] Even many opponents of wider health reform supported the idea of national responsibility for a veterans' health service.[86] The AMA, however, challenged this near-unanimous support for public responsibility for veterans' care. What the AMA sought to do was not to reject the government's support for veterans' care but to limit the beneficiaries of the VA health care.

The AMA portrayed the VA health care as an example of the perils of public health insurance. The VA health care conventionally provided hospital care not only to veterans who had service-related disabilities but also to ones with nonservice-related disabilities. The AMA feared that the increase of the latter group would intrude on the social and economic status of private practitioners. In September 1943, Edward J. McCormick, president of the AMA, warned Americans, "During the year Sep. 1, 1951, to August 31, 1952, 85 per cent of the 500,000 veterans treated were patients with nonservice connected disabilities." "If a vast and proliferating VA empire is to keep pace with this enormous demand," he continued, "it is hard to see how the process can be brought to a stop short of a completely nationalized medical profession and system of hospitals."[87]

The American Legion, which was one of the fathers of the G.I. Bill and benefited from the VA health care, was defensive toward the AMA's criticism because of its own ideology and historical timing. In July 1949, the *American Legion Magazine* had a report titled, "The Growing Attack on Veterans' Benefits,"

written by Perry Brown, national commander of the American Legion. In the report, Brown warned its members that "hard-won veterans' benefits are under dangerous, irresponsible, and, in some cases, greedy attack from many sides."[88] In particular, he pointed out that the AMA and the American Hospital Association had both suggested cutbacks of the VA hospitals, which, they claimed, served many veterans with non-service-related disabilities. But Brown could not effectively respond to the criticism. He asserted, "Veterans' benefits are part of the cost of war—and it is a cowardly act to renege on them in the security of victory."[89] He continued that "a non-service-connected veteran is simply one whose disability has not *yet* been determined to be service-connected."[90] Finally, he wrote, "The American Legion is opposed to socialized medicine if only because of the experience we had with it in the VA prior to 1946. We certainly will not be a party to restoring bureaucratic medicine in VA hospitals."[91] It was hard for the American Legion to play both sides: opposing socialized medicine and promoting public health care for veterans. The American Legion could not convincingly explain why VA health care would need to be expanded and continue to see veterans with non-service-related disabilities.

The American Legion faced a dilemma on the issue of the VA health care. Its ultimate goal was to protect the country. To do so, it had to protect the core fundamental ideas on which the United States was based. The American Legion became defensive when the AMA labeled the VA health care socialized medicine and an un-American institution. To make it worse, the American Legion had to fight to protect the United States from communism from the late 1940s to the early 1950s when the Cold War started and McCarthyism spread. The American Legion was a standard-bearer of anti-communism. It "worked closely with the FBI and the rest of the anti-Communist network, often spearheading local campaigns against alleged Communist influence in schools or other institutions."[92] To combat communism, James F. O'Neil insisted that "surely the American Legion's more than three million members can arouse, warn, and instruct the remaining 139 millions of our citizens. The task is clear, the weapons and tools are available—let's go!"[93] With its ideology, it was difficult for the American Legion to call for the expansion of the VA health care.

The federal government also did not have the capacity to make a counterattack to the AMA's accusation. The Veterans Administration opposed Truman's health care plan because the VA considered his proposal "a threat to its growing complex of medical facilities and services for disabled veterans."[94] Although Murray tried to obtain the VA's support for his co-sponsored bill, the VA refused to support it in a congressional hearing.[95] In addition, the Children's Bureau in

the PHS distanced itself from the movement for universal health insurance because in the postwar "return to normalcy" environment it put the highest priority on maternal and infant care. The Children's Bureau did not want to jeopardize its own priority by committing to the movement to create universal health insurance.[96]

By the end of 1953, the AMA's oppositions and the American Legion's lack of decisiveness contributed to the tightening of the VA means test so that veterans would not "leave themselves open to possible action for filing a false statement of inability to pay."[97] The House of Delegates of the AMA continued to be cautious about this issue of veterans with non-service-related disabilities, unanimously agreeing in 1954 that "Veterans Administration hospital and medical care for veterans with non-service-connected disabilities be discontinued except in the case of war veterans with tuberculosis or psychiatric or neurological disorders when the veteran is unable to afford such care and where local facilities are inadequate."[98]

The VA health care could have gone one of two ways after the war. The first route was that it could have turned into a larger public health insurance program, including not only veterans but also the rest of the population. The second route was that it could have continued to target veterans only. As we have seen, the VA health service took the latter route. This choice can also be explained by the fact that the United States did not feel the same urgency to rebuild its nation that other countries did. Moreover, lacking that urgency, the fragmented nature of the American political structure contributed to hindering decisive governmental action. But the story of the VA health care did not end here. The AMA succeeded in further restricting the VA health care only to those with service-related disabilities and introducing a means test for those who applied to receive care for non-service-related disabilities. Therefore, the government lost two battles with the AMA; it could not introduce universal health insurance or guarantee health care for all veterans no matter what the cause of their disabilities were.

By the time Dwight D. Eisenhower won the presidential election in 1952, it had become clear that the reformers' dream was buried. In April 1949, Truman again sent a special message to Congress to recommend a comprehensive reform of health care. An omnibus health bill was introduced under the newly elected Democratic majorities in both houses, but again it never got out of committee. In the same year, Truman sought further integration of the social welfare administration and pushed for universal health insurance by upgrading the FSA to departmental status. His effort failed due to the opposition by the

same coalition that opposed national health insurance.[99] These failures signaled the end of the intensive efforts of reformers in the federal government.

Truman's last, failed action in health insurance took place in December 1951. He established the President's Commission on the Health Needs of the Nation by utilizing the Emergency Fund for the President in national defense. Truman made every effort to include a wide range of interests on this committee, but the AMA turned down Truman's request to send its own representative.[100] This again confirmed that Truman could not have any hope for universal health insurance. It made it clear that a non-devastating war could not produce radical reform. The mobilization for the Korean War was neither long nor deep enough to boost the movement toward radical reform. The Korean War lasted three years, from June 1950 to July 1953, and mobilized only about 2.3% of the population at its peak, much less than the mobilization of 9.1% in 1945.[101] There was also a discussion about reviving the EMIC for wives of soldiers who served in the Korean War, but the federal government did not succeed with even this small program, because the AMA and the AHA contended that "there was 'no demonstrated need.'"[102] Seeing his proposal go nowhere, Truman had to surrender his hope for universal health insurance.

In 1952, Truman omitted his plea for universal health insurance from the State of the Union address. In the 1952 presidential election, held in the middle of the Korean War, Democratic candidate Adlai Stevenson distanced himself from Truman's health care plan.[103] The new Republican president, Dwight Eisenhower, supported the private provision of health insurance.[104] In 1954, it was clarified that individuals now could deduct their medical expenses from their income for tax purposes, which was a major step toward consolidating the dominance of private health insurance in the United States.[105]

In 1965 the United States added two public health insurance programs, Medicaid for the poor and Medicare for the aged and disabled. But all efforts, including those of President Barack H. Obama, to introduce a universal health insurance system have failed, and voluntary private health insurance and public programs for select groups are the main components of the American health insurance system. Of course, many factors contributed to the divergent development of the health insurance systems in Japan and the United States after 1952, but the wartime legacy cannot be ignored.

CHAPTER SIX

Restoring the Public Health Insurance System

Japan, 1945–1952

During the early period of World War II, Japan created the National Health Insurance Law (NHI), the White-Collar Workers' Health Insurance Law, and the Seamen's Insurance Law. Later in the war, Japan amended the Health Insurance Law and the NHI to expand their coverage. As a result, by the end of the war Japan had adopted a public health insurance system that offered near-universal coverage through multiple programs.

Because of the attack on the mainland and the postwar economic depression, however, the public health insurance programs faced financial difficulties, and many of the national health insurance associations became inactive. Many doctors refused to accept public health insurance patients because the health insurance fees set by the government did not keep up with inflation.[1] Consequently, a key task of the Japanese government and the American-led occupation authority was to reactivate and rationalize the national health insurance programs, but the question was what kind of reform should be made.

By the end of the military occupation in 1952, the basic structure of Japan's health insurance system remained almost the same as it was at the end of the war. Three factors have to be considered. First, as the policy feedback argument suggests, the wartime policy influenced policy development in the postwar period. No one made a serious effort to abolish the wartime policy and get back to the prewar condition. Second, the war brought to Japan not only the wartime policy but also the destruction of massive parts of the economy and society. Health insurance became a means for the government to recover from the devastating circumstances. The last thing the war left to Japan was the U.S.-led

military occupation. No policy change could be undertaken in Japan if the occupation force did not approve. Therefore, we have to take these three factors—the wartime policy legacy, the devastation of the war, and the military occupation—into account in explaining the immediate postwar development of health insurance in Japan.

A MOVEMENT TOWARD RADICAL REFORM, 1945–48

Following the Japanese surrender, the military occupation led by the United States began in September 1945. The United States adopted indirect governance, which was to utilize the Japanese government for implementation of the occupation policy. In this institutional setting, the United States played a major role in designing the postwar society, politics, and economy of Japan.

At the end of the war, many Japanese suffered from injuries from air raids and malnutrition. The spread of communicable diseases made the conditions worse. The number of patients who got dysentery, typhoid fever, smallpox, and diphtheria increased during the war and the postwar years.[2] There was great demand for access to health care. But public health insurance programs faced difficulties after the war. National Health Insurance associations, for example, had a financial crisis, and many ceased operations by the end of the war: only 67.1% of NHI associations were active in 1945.[3] As a key component of the social safety net, a functioning health care system would facilitate economic recovery, would contribute to social stability, and, therefore, would be a critical task for rebuilding Japan. The occupation authority, cooperating with the reform-minded Japanese government officials and scholars, sought to use health insurance as a means to help Japanese people recover from the war devastation and rebuild Japan as a democratic country.[4] In this circumstance, the occupation authority and the Japanese government moved toward radical reform of health insurance.

Health Insurance Reform under Dual Governance

Health care issues were not mentioned in the postwar planning by the American agencies such as the State-War-Navy Coordinating Committee.[5] In fact, no representatives from the Social Security Administration were included in its Subcommittee on the Far East.[6] At the beginning of the occupation, the occupation government began to pay attention to public health but merely sought to improve it only insofar as it protected its occupying forces.[7] Occupation of-

ficials soon realized, however, that health care would contribute to the overall recovery of Japan.

Organizationally, the occupation combined military and civil functions under the broad authority of General Douglas MacArthur, the Supreme Commander for Allied Powers (SCAP). Although other Allied nations played a minor role in the military occupation of Japan, the final authority belonged to the United States, more specifically to General MacArthur, as designated by the United States.[8] Within General Headquarters (GHQ), fourteen social staff sections, roughly divided along functional lines that mirrored the structure of government ministries, drafted and transmitted specific directives to be implemented by their Japanese counterparts.[9] Although led by military officers, these special staff sections contained a full complement of civilian administrators, many of whom had gained significant experience in New Deal agencies back in the United States.[10] In the case of public health, which included the coordination of medical care, refugee relief, and the operation of social programs such as health insurance, responsibility fell to the Public Health and Welfare Section (PHW) of SCAP under the leadership of a military doctor, Brigadier General Crawford F. Sams.[11] Like other staff sections, civilian officials in the PHW, rather than military officers, carried out most of the tasks. A 1948 listing of division and branch chiefs included six members of the military and thirty-eight civilians.[12]

It is important to understand these two important figures, Sams and MacArthur, in analyzing what GHQ did in health insurance reform in Japan. The two men shared quite a few political tendencies. They were trained as military officers, were authoritarian in style, believed in classical liberalism, despised communism, sought professional promotion, and cooperated with Japanese conservatives.[13] MacArthur's authoritarian characteristics were well-known, going back to his suppression of the Bonus March in Washington, D.C., in December 1932.[14] Despite their conservative beliefs, what MacArthur and Sams actually did in Japan was not what many of their conservative contemporaries in the United States would have been likely to do. Courtney Whitney, MacArthur's close staff member, was in fact a progressive officer.[15] Although he later complained that "there were many communists in the PH&W," Sams supported the creation of progressive measures, such as the Daily Life Security Law in 1946, the Unemployment Insurance Law in 1947, and the Child Welfare Law in 1948. MacArthur and Sams both adopted progressive measures for achieving their final goals: demilitarizing, democratizing, and liberalizing Japan.

On the Japanese side, the Japanese Ministry of Health and Welfare (MHW) was responsible for health insurance issues. During the purge of public service

personnel by GHQ, many officials in the Home Ministry were removed, and the ministry itself was abolished for its responsibility for the war. The MHW, by contrast, remained almost intact with the exception of a few elites, including Koizumi Chikahiko, who had committed suicide. The MHW also enjoyed the political support of the occupation authorities. As Toshio Tatara has pointed out, "The relationship between PH&W, SCAP and the Ministry of [Health and] Welfare was particularly a good one, and there were many direct contacts between the personnel of both organizations."[16]

The new Japanese constitution also encouraged reformers by articulating the idea of the government's responsibility for social welfare. Article 25 in the Constitution stipulated, "All people have the right to maintain the minimum standards of wholesome and cultured living. In all spheres of life, the state shall use its endeavors for the promotion and extension of social welfare, and of public health."[17] This aided reformers, who gained power within the MHW to promote the government's responsibility in social welfare policies.

In contrast to empowered reformers in the government, Japanese doctors were in a defensive position. By the end of the war, Japanese doctors were enmeshed in the government's effort to nationalize the health care system. The nationalized Japan Medical Association faced criticism for its contribution to the war. In October 1947, the "nationalized" JMA was dissolved, and a new JMA was formed to be "dedicated to promote medical ethics, to improve and propagate medical knowledge and techniques, and to advance public health as a means of improving the social welfare."[18] While it was undergoing this reorganization, the new JMA could not actively participate in the postwar health care reform debate.[19] The occupation government and the MHW dominated the process of health care legislation without much interference by the JMA.

Efforts to Integrate and Centralize National Health Insurance

GHQ's initial activities in health care were for "protecting American occupation forces and promoting occupation governance."[20] But GHQ soon realized that the devastated economy was an obstacle to Japan's recovery and that its initial crisis-oriented approach needed to be replaced by long-range planning. Health insurance reform became an increasingly important issue.[21] In December 1945, the Labor Advisory Committee attached to the Economics and Scientific Section reviewed Japanese social policies and made recommendations to the PHW regarding SCAP activities in this area. The twelve members who made up the committee brought with them expertise in labor relations, social

insurance, and wage policy development from their work in New Deal agencies such as the National Labor Relations Board, the Social Security Board, and the War Manpower Commission. The chair of the Labor Advisory Committee, for example, was Paul L. Stanchfield, formerly of the Office for War Mobilization and the War Production Board.[22]

Consonant with their backgrounds in New Deal and wartime planning agencies, the occupation officials involved in social policy matters brought with them a view of activist government.[23] For example, a SCAP directive issued in February 1946 setting out occupation goals in the area of social policy called for the creation of a single government agency to administer a range of expanded government programs in areas such as pensions, unemployment insurance, and public assistance.[24]

On the issue of health insurance, the Labor Advisory Committee praised Japan's near-universal if fragmented system of social insurance and compared it favorably to Western nations', especially "the broad coverage of the National Health Insurance program . . . in providing health security for farmers and self-employed persons."[25] However, the Labor Advisory Committee report also concluded that "a comprehensive reform of social insurance can and should be undertaken."[26] In particular, an interim report dated April 5, 1946, noted that, given separate programs for industrial wage earners, farmers, and the self-employed, the PHW should consider "the feasibility of consolidating some or all of these programs into a unified, comprehensive social insurance system."[27] Such a comprehensive reform would likely resemble the National Health Service, which would soon be established in Britain at the time. In fact, when addressing the matter of doctors' compensation in its final report of May 1946, the committee noted, "Consideration should be given to a compensation scheme patterned on the British model."[28] That is, the committee recommended that doctors receive compensation based on the number of their patients, as envisioned in the National Health Service Bill under review at the time in the British House of Commons.

As these specific occupation policies took shape, civilian officials in the PHW drew closer to progressive health care reformers in the United States. In April 1946, following the recommendations of the Labor Advisory Committee, the PHW requested that SCAP replace its single social insurance officer with a Social Security and Insurance Division.[29] Approved in June 1946, the new division included twelve new staff positions divided among three branches for health insurance, social security, and economic analysis.[30] Recruitment for the position of division chief as well as the heads of the three

branches began in the fall of 1946. Stanchfield, chair of the Labor Advisory Committee, declined the position of division chief but agreed to help fill the post. Upon his return to the United States in January 1947, Stanchfield turned to the Social Security Administration.[31] Two Social Security Administration employees, Leonard Anton and Lee Janis, agreed to lead the Social Insurance Branch and Health Insurance Branch, respectively. For the position of division chief, Stanchfield recommended William Wandel, a Columbia Ph.D. who had worked for the Social Security Board since 1935. All three received one-year leaves from the Social Security Administration's longtime commissioner, Arthur Altmeyer.[32]

During his visit, Stanchfield asked Altmeyer whether he could lead a mission to Japan. Sams enthusiastically embraced the idea of inviting Altmeyer as a member of the coming mission, believing that such a visit "would be immensely valuable in arousing Japanese interest in social security problems, encouraging early action by [the] Diet and emphasizing [the] need for [an] integrated program properly geared to Japan's needs and economic conditions."[33] In March 1947, Sams also issued a formal invitation and requested that Wilbur Cohen, Altmeyer's longtime assistant, and Isidore Falk, the chief of the Bureau of Statistics in the Social Security Administration, also be included.[34] Cohen and Falk were both central figures in the struggle for national health insurance in the United States; Theodore Marmor described them as "two of the men who had had most to do with the drafting of health insurance proposals since 1935."[35] Although Sams's invitations for Altmeyer, Cohen, and Falk were not granted, the story shows that the health care reform in Japan was not isolated from political interests in the United States.

The Social Security Mission led by Wandel arrived in August 1947. The mission comprised five members, including Burnet M. Davis. Davis, who worked for the U.S. Public Health Service, was the son of Michael Davis, chair of the Committee for the Nation's Health, the chief group lobbying on behalf of President Harry S Truman's health care plan. Burnet Davis had just returned from a mission to London, where he was attached to the British Ministry of Health during the drafting of the National Health Service bill.[36] The Social Security Mission reflected the occupation government's goal of the comprehensive reform of Japanese health care, one that envisioned the amalgamation of the various health insurance programs into a single national program. According to a PHW memorandum, the Mission "will consult . . . for [the] purpose of drafting a National Health Bill which will incorporate a unified national health insurance program with a National Medical Care Program."[37]

By the summer of 1947, the occupation policy on health care had begun to take shape. Staffed by civilian officials with ties to health care reformers in the United States, the Social Security Division in the PHW envisioned a comprehensive program of Japanese social insurance, including a single compulsory health insurance program. In June 1947, GHQ recommended that the NHI be strengthened by increasing the government's subsidy and that the various health insurance programs be integrated into a single national health insurance program.[38] As new division chief Wandel wrote to Falk, his former colleague at the Social Security Administration in June 1947, "Health insurance is the major field of social security in Japan. . . . Permanent revision requires amalgamating the National Health Insurance Law with the Health Insurance Law, on a compulsory basis."[39] Indeed, the singular focus of occupation officials made the comprehensive reform of Japanese health insurance seemingly within reach in 1947. As Wandel confided to Falk, "I find the work here very interesting and engrossing . . . there are real possibilities for accomplishment." With some prescience, however, Wandel added, "One is reminded forcibly of the apparently universal character of the conflict of established interests."[40]

Many of the Japanese officials and scholars at the center of health policy debates during the occupation also supported proposals for the amalgamation of various health insurance programs into a single, compulsory national health program. The Advisory Council on the Social Insurance System (Shakai Hoken Seido Shingikai) was established in December 1945, mainly to discuss GHQ's directive (SCAPIN 338) abolishing veterans' benefits. This discussion led the MHW to push for the reform of other social security programs.[41] In March 1946, the MHW established the Social Insurance Investigation Committee (Shakai Hoken Seido Chōsakai) to conduct a wholesale review of the social security system, including health insurance.[42] Composed of ministry officials and a number of reform-minded Japanese scholars with social policy expertise, the committee issued a report in December 1946 calling for the integration of the multiple health insurance programs into a single national program. In particular, the committee proposed that the Health Insurance Law (workplace-based health insurance) and the National Health Insurance Law (residence-based health insurance) should be merged into a residence-based health insurance program.[43] Moreover, in October 1947 the committee issued the Social Security System Outline (Shakai Hoshō Seido Yōkō), which called for "not patchwork but a progressive, comprehensive social security system."[44] The members, encouraged by the fact that other social security measures, such as the Labor Standard Law (Rōdō Kijun Hō) and

the Unemployment Insurance Law, had passed in 1947, moved toward the establishment of a comprehensive social security system.[45]

The members of the committee kept in good contact with officials in the PHW. In June 1947, the members and officials in the PHW and the MHW regularly began to meet to discuss the Japanese social security system.[46] On June 13, they had a discussion specifically about health insurance.[47] Reform-minded officials in the MHW and the PHW shared an admiration of British policy developments during and after World War II. Describing the discussions in Japanese circles about the development of a comprehensive system of social insurance, the Labor Advisory Committee noted in 1946, "The influence of foreign thinking, particularly of the British 'Beveridge Report,' is clearly discernible."[48] According to Suetaka Makoto, a member of the committee, "The Beveridge Plan was the model of the plan for the committee. . . . Its principal spirit was that in a liberal society the new Japanese social security system had to guarantee a minimum condition of life by protecting people from poverty."[49] Because the Social Security System Outline was to resemble the Beveridge Report, it was called the "Japanese Beveridge Plan."[50]

Not all Japanese were as enthusiastic about a British-style national health service as the MHW or the members of the Social Insurance Investigation Committee. Officials at the Ministry of Finance (Ōkurashō), for example, early on expressed concern about the cost of any reform proposal. As *Asahi Shimbun* described it, because the Grand Plan envisioned huge governmental subsidies, "some see the proposal of the Social Insurance Investigation Committee as a dream, one that the realistic officials in the Ministry of Finance are reluctant to make realized."[51] However, so long as the Americans remained enthusiastic about reform, the Ministry of Finance's concerns were peripheral to most of the social policy debates. In the area of public assistance, for example, SCAP forced the Ministry of Finance to accept a fifteen-fold increase in its budget allocation for the MHW in 1946 to cover the anticipated cost of the new Daily Life Security Law.[52]

In sum, the movement to bring about the integration and centralization of health insurance intensified in Japan from 1945 to 1947. The social insurance specialists in the occupation authority leaned toward integration of national health insurance programs for Japan's recovery. Officials in the MHW, encouraged by the Beveridge Report, also sought to integrate the fragmented Japanese social security system. As a result, with the support of the occupation authority, Japan had an opportunity to change its fragmented health insurance system into a more integrated one. But the opportunity would soon be lost.

THE RISE OF PIECEMEAL REFORMS, 1948–52

In the second half of the occupation period, policies to promote democracy and progressive social policy were replaced by conservative fiscal policy. This policy change is often called "reverse course." The shift of the postwar health insurance reform from a radical to a moderate one is also an example of this reverse course.[53] But an important event occurred in the field of health insurance policy before the deflation policy took place. It was that the American domestic interests began to influence what the occupation authority was doing to change the Japanese health insurance system.

In the spring of 1947, the movement toward radical reform of health insurance appeared to gain more support with the upcoming visit by officials from the U.S. Social Security Administration. This movement, however, suffered a setback when American domestic interests decisively opposed the occupation government's effort to integrate the health insurance programs in Japan; the Social Security Mission became part of the political struggle about health insurance in the United States. The AMA and its allies, which were trying to kill the Wagner-Murray-Dingell bill reflecting Truman's health care plan, responded with hostility when it became clear that the occupation government was about to do something which the United States had not done. The opposition from the American domestic forces, along with a deflation policy the United States implemented in the late 1948, led Japan to adopt piecemeal reform rather than radical reform.

Opposition from American Domestic Interests

As described in the previous chapter, Forest A. Harness (R-Indiana), head of the House Subcommittee on Government Publicity and Propaganda, made efforts to attack the government officials supporting Truman's health care plan. When Harness found out that the Social Security Mission was going to arrive in Japan, he directed his attack to Japan. In a cable sent to MacArthur on August 20, 1947, Harness described "evidence of a general program to implant compulsory health insurance in various states and foreign nations."[54] Describing a "World Program for Socialized Medicine," Harness warned that the Social Security Mission was composed of "militant advocates [of the] Wagner-Murray-Dingell bill for compulsory health insurance" sent to Japan "for the purpose of drafting a national health bill which will incorporate a unified national health program."[55] Harness concluded, "The real purpose of the mission is not to assist

Japan in working out her basic problems in health and welfare, but to force upon that country a compulsory system of socialized medicine."[56]

Marjorie Shearon, who aided Harness and others hostile to Truman's plan, also played a role in discrediting what the occupation government was trying to do in Japan. She found the Japan story to be another opportunity to discredit the reformers in the Truman administration. In a nationally distributed newsletter dated August 20, Shearon reported: "Over 2 weeks ago I gave to Frank T. Bow, of the Harness subcommittee, the information which has enabled him to expose the grandiose plans of Falk, Altmeyer, Cohen, and Miss Mulliner [Senator Wagner's protégé] to socialize medicine in Japan, and to foist a WMD bill on the defenseless Japanese."[57] Shearon's work on the Harness Subcommittee was closely linked to the AMA's campaign as well. In a letter sent to Crawford Sams, George Lull, head of the AMA, expressed his strong opposition to the Social Security Mission and the promotion of "socialized" medicine in Japan.[58] In the ensuing weeks, MacArthur received letters from concerned doctors around the United States, urging that he "not support or abet the socialistic and undemocratic proposal of the Social Security mission to Japan which has as its purpose the 'putting over' of compulsory sickness insurance on this vanquished nation."[59] One doctor from San Diego quoted verbatim from portions of the Harness Subcommittee report and sent MacArthur a copy of Shearon's "Blueprint for the Nationalization of Medicine," which he described as "scientific . . . authoritative and thoroughly documented."[60]

In his reply, MacArthur assured these doctors that "there is no slightest concept at this headquarters of any socialized medicine in Japan."[61] However, in a letter to Forest Harness, MacArthur stressed that Japan had adopted a different health insurance system from the United States, and noted, "Japan . . . has had extensive health insurance and various forms of social insurance developed piecemeal over more than twenty years." Moreover, MacArthur added that the Japanese government "has repeatedly asked for the advice and assistance which could be rendered by a group of American experts in the social security field."[62] In September 1947, the *Journal of the American Medical Association* reported, "The War Department disclosed that General MacArthur had denied allegations by Representative Harness of Indiana, chairman of a House Expenditures subcommittee studying propaganda."[63] Meanwhile, the Social Security Mission departed for Japan as scheduled on August 28, 1947, with MacArthur's continued support. When the group completed its work in December 1947, MacArthur sent a copy of the report to Harness and to the president of the AMA.[64]

The Social Security Mission report, called the Wandel Report and eventually submitted to the Japanese government in June 1948, did not embrace an integrated and compulsory health insurance program as much as previous recommendations and proposals by the Japanese government or the occupation authorities had. Instead, the report claimed, "Under this economic situation, Japan should adopt gradual steps toward universal health insurance coverage for the people." The report proposed that the Health Insurance Law and the NHI remain two core components in the health insurance system without clearly recommending their integration. This was an apparent shift from the policy stance that the occupation government had taken.[65] In fact, some members of the Social Security Mission opposed the moderate stance toward reform. Barkev Sanders, a statistician from the Social Security Administration, submitted a minority report to SCAP and the PHW in November 1947. In it, Sanders wrote: "The majority of the Mission advises the Japanese against the adoption of a program at this time which would undertake to provide prepaid medical service to the whole population. In my opinion this advice is unwarranted. . . . If, through their elected representatives, the Japanese people should be ready to enact such a program, I can see no technical or practical consideration of sufficient moment to make it inadvisable for them to take that step now."[66] Sanders went on to dispute the Mission's various arguments for postponing comprehensive reform, such as the status of the Japanese economy or the administrative capacity of the MHW. Instead, Sanders urged SCAP to seize the opportunity for comprehensive reform. "Major social changes are effected only in period of crisis," Sanders wrote. Quoting Sir William Beveridge's famous 1942 report on social insurance in Britain, Sanders added, "A revolutionary moment in the world's history is a time for revolutions, not for patching."[67] His report disputed the notion that economic factors in Japan posed an obstacle to the integration of national health insurance programs.

The AMA took action against even the moderate majority report. In particular, the AMA opposed the recommendations to strengthen the central administrative capacity of the Japanese MHW. After noting "fundamental weakness, especially in administrative relationships essential to the success of any kind of social insurance program," the Mission report recommended that "full authority and responsibility" for social policy reside within the Japanese Ministry of Health and Welfare.[68] Responding to this recommendation, AMA President George Lull wrote to Sams that "the administration and authority [of health insurance] should be decentralized, not centralized." Referring to the previous defeats of national health legislation before Congress, Lull added that "the United States is continuously proclaimed and has certainly been recognized as

the last bulwark for democracy in the world and it refused to accept national health insurance. Japan, which is to become a democracy, should not adopt it [either]."[69]

To Sams, the AMA criticism ignored the institutional context in which occupation policies were operating. Speaking to a group of American doctors in 1954, for example, Sams stated, "In establishing any government health or welfare organization it is obvious that it necessarily will have to conform to the general organization of the government of the nation, which in turn should be adapted to the social structure of that nation."[70] Specifically, government-provided health care enjoyed a constitutional imprimatur in Japan not found in the United States. Under the influence of progressive reformers in the occupation government, and possibly Sams himself, the new Japanese constitution guaranteed the minimum standards of wholesome and cultured living.[71] Comparing this constitutional basis of health policy in Japan with that in the United States, Sams pointed out: "Article 25 charges the [Japanese] government with the responsibilities of promoting the health, welfare, and security of the people. . . . In the United States our public health and welfare legislation is largely state or local and is based on the police power of the states . . . since we have no provision in the United States Constitution for the federal government to concern itself directly with the health of the people."[72] In an effort to appease the AMA, Sams invited its representatives to "visit Japan, and judge for themselves the situation here."[73]

In August of 1948, nearly a year after the Social Security Mission, members of the AMA arrived in Japan to investigate "national health insurance and its relationship to the medical profession in Japan."[74] The *Journal of the American Medical Association* reported the mission with a picture of members of the JMA and officials from GHQ and the Japanese government.[75] The AMA Mission report sent to Sams in October 1948 reiterated their concerns about concentrating too much authority over health care in the hands of the MHW. Members of the mission warned that such a concentration of authority over medicine could lead to the return of a totalitarian government in Japan. To avert this threat, the AMA Mission report recommended that the occupation promote a health care system that more closely resembled the one found in the United States: employment-based private insurance coupled with means-tested public programs for the poor.[76] Sams attended the AMA's convention to assure them that total nationalization of medicine would not occur in Japan.[77]

The twelve-month period from August 1947 to August 1948 saw occupation policies toward health insurance become embroiled in the domestic political

struggle over national health insurance in the United States. Previously, occupation officials had pressed for a comprehensive reform of Japanese health policy and turned to proponents of national health insurance in the United States such as Falk and Cohen to help them formulate new policies for Japan. Now, opponents of national health insurance, such as the AMA, Harness, and Shearon, were using the Japanese story to mobilize a network of doctors and medical associations to fight against the efforts by the Truman administration to pass health care legislation in the United States. As one concerned doctor wrote MacArthur, "The federal officials involved are going the long way around to make this easier for themselves to pass legislation of a similar nature through the Congress."[78] At the same time that the AMA and other opponents of national health insurance were organizing the defeat of legislative proposals in the United States, the movement to integrate national health insurance programs and bring about comprehensive reform also lost momentum in Japan.

Meanwhile, the Japanese government stressed more moderate reforms over a drastic plan to integrate the multiple health insurance programs into a single program on a compulsory basis. Support for piecemeal reform prevailed by 1948, and the government produced policies for incrementally improving the existing programs. In January 1948, the MHW began to work on revising the National Health Insurance Law to strengthen the finances of the program and to restart the ceased local health insurance associations. It proposed that the administrative entities be local governments and that participation of residents be compulsory. But GHQ, now claiming that compulsory participation was against the idea of democracy, suggested that compulsory participation required majority vote by the residents. As a result, in April the Diet passed a revision of the NHI that assigned basic responsibility to local governments for the administration of health insurance associations, and the revision made the participation of residents compulsory when residents' representatives, usually their local legislature, decided on the creation of the NHI.[79] This meant that once a National Health Insurance association was established in a municipality by its legislature, its residents had to participate in the program. Kojima Yonekichi, an official in the MHW, explained that the compulsory nature of the NHI was not antithetical to democracy but would merely help to avoid adverse selection.[80] There was little controversy over the 1948 amendment.[81]

As another moderate reform, the government dealt with the problem of delayed insurance payments to doctors. The JMA was responsible for supervising doctors and reviewing the payment process before it was dissolved, but in February 1948 the government decided to create committees for guiding

health insurance doctors (*hoken-i sidō iinkai*) at the national and local levels. The task of insurance payment now belonged to three bodies for multiple national health insurance programs: the Social Insurance Association (Shakai Hoken Kumiai) for the GMHI and the Seamen's Insurance Law; the Health Insurance Association Federation (Kenkōhoken Kumiai Rengōkai) for the AMHI; and the National Health Insurance Federation (Kokumin Kenkōhoken Rengōkai) for the NHI. To further coordinate the insurance collection and payment processes, in August 1948 the government established the Social Insurance Medical Fee Payment Fund (Shakai Hoken Shinryō Hōshū Shiharai Kikin).[82]

There were some government officials and scholars who wished to turn these moderate reforms into a drastic reform. *The Fifty-Year History of the Ministry of Health and Welfare* (*Koseishō Gojyūnenshi*), published in 1988, stated that the revision of the NHI in 1948 originally meant a temporary measure to improve financial flexibility and "a step toward integration of social security programs."[83] The government, however, made piecemeal reforms without suggesting a clear promise for eventual integration of the various national health insurance programs, and the piecemeal reform, seen retrospectively, diminished the chances for comprehensive reform. Without GHQ's affirmation, the MHW's reform-minded officials and scholars could not maintain the momentum to transfer multiple health insurance programs into a single national health insurance program. In the following period, the second half of the American occupation, the dream of comprehensive reform became unattainable.

Consolidating Wartime Policy

By late 1948, GHQ's clear change of policy priorities put the integration of national health insurance programs aside in favor of patchwork reforms for specific programs. In December 1948, the Department of State and the Department of Defense in the United States presented "Nine Disciplines for Economic Stabilization," which proposed a currency exchange rate, a balanced budget, reform of governmental subsidies, and a strengthened taxation system in Japan.[84] In February 1949, Detroit banker Joseph Dodge arrived in Japan under direction from Washington to stimulate Japanese exports and bring hyperinflation under control. Under the "Dodge Line," the occupation imposed a series of draconian cuts in public spending, tight money policies, and balanced budget requirements on the Japanese government that made further expansions of social welfare spending especially difficult.[85] Under this strict deflation policy, comprehensive reform in Japan became much less likely.

The conservative fiscal policy undermined the financing of the national health insurance programs, which were already suffering from high inflation. The national fee schedule could not keep up with inflation; many doctors refused to accept health insurance; and people concluded that health insurance was for the poor. The Health Insurance Law dealt with its financial problems by increasing the premium of the GMHI, which dealt with workers in small companies, from 3.6% of wages in 1947, to 4.0% in 1948, and to 5.5% in 1949. But these were not enough. In 1949, the Health Insurance Law had a 3.1-billion-yen deficit.[86]

The NHI also faced financial problems—indeed, worse problems than many other programs. Unlike other workplace-based national health insurance programs, the insured in the NHI, mainly farmers and other self-employed people, did not have employers paying part of their premium. Moreover, the municipalities had difficulty collecting the premiums, because the NHI premium was not part of the municipality taxation system. Municipalities had limited national subsidies that covered 70% of administration costs, but they usually used the general revenue to cover the deficit of the NHI. Although the administration of National Health Insurance associations was transferred from quasi-public or private associations to municipalities in 1948, the financial structure of the NHI remained intact. An amendment in 1951 helped improve the finances of the NHI by including the premium in the taxation of municipalities. In the same year, the government subsidy covered all administration costs.[87] But the NHI's fundamental problem remained the same: a heavy financial burden was imposed upon the insured.

As the Social Security Mission report recommended, the Japanese government in December 1948 established the Advisory Council on Social Security (Shakai Hoshō Seido Shingikai), which replaced the Social Insurance Investigation Committee. The new council played a central role in proposing social security reforms. As requested in the Social Security Mission report, the council was on the cabinet level and had the authority not only to be consulted by the government for specific issues but also to study, discuss, and recommend policies. It included forty members, most of whom were councilors, government officials, and scholars. All policies relating to social security had to be decided on in consultation with the council.[88]

In November 1949, the council released a memorandum to show the direction of social security reform. It read:

> The social security system is a fundamental right guaranteed by the Constitution. It equally provides people with economic compensation for old-age, permanent

> and temporary disabilities, unemployment, sickness, death, and delivery. It eliminates people's anxiety and maintains the social order, and achieves the ideal of democracy. Although this Council wished to build a comprehensive social security system, it is difficult to do so because of the current poor economic conditions. Therefore, the Council hopes to gradually build a social security system within the limit. . . . Regarding health care, public medical facilities should be expanded under arranged planning; a good relationship with private solo-practitioners should be established; and public health measures should be expanded.[89]

The memorandum indicated that the council also did not deal with the integration of the programs as an immediate priority. Rather, the council proposed piecemeal reforms, some of which were blocked by GHQ. In October 1950, the council submitted a report entitled "Recommendation with Respect to a Social Security System," to Prime Minister Yoshida Shigeru. In the health insurance area, it stressed the importance of universal coverage by reorganizing workplace-based programs and making the rest of the population enroll in the NHI. The recommendation also requested an increase in government expenditures to cover some of the non-administrative costs, which would ease the financial pressure experienced by the NHI.[90]

GHQ showed its opposition to the Advisory Council's recommendation to establish universal national health insurance. With the financial situation of Japan in mind, PHW stated, "Compulsory national health insurance is not acceptable under SCAP policy."[91] This was a clear retreat from what the occupation authority had wished to do before 1948. What GHQ wanted the Japanese government to do in 1950 was merely to mend the existing programs. GHQ's disapproval meant that no radical change could occur in Japan before the end of the occupation.[92]

In sum, the devastation caused by World War II gave the occupation authority and the Japanese government the justification to stabilize and rebuild the nation. Health insurance became a means in their efforts. For this reason, during the first few years after the war they both pushed for a radical proposal to integrate multiple national health insurance programs, many of which had been created during the war. But the American occupation brought Japan its domestic health care politics as well. As the AMA and its allies attacked what MacArthur was trying to do in Japan as un-American, health insurance reform began to shift its emphasis from radical policy change to piecemeal change. Furthermore, the American government's new financial policies, as represented in the Dodge Plan, made it more difficult to integrate multiple programs.

As a result, although the administrative and financial policy changes under the occupation at least buoyed the national health insurance programs in Japan during a stormy period, Japan could not go further to adopt recommendations for radical reform.[93]

The health insurance systems that existed in Japan by 1952 remain almost the same to this day. After the American occupation ended, private alternatives never came into sight. Furthermore, the fragmented nature of the Japanese health insurance system was enhanced by the establishment of two additional programs in 1953, the Day Labor National Health Insurance Law (Hiyatoi Rōdōsha Kenkōhoken) and the Private School Mutual Association Law (Shigaku Gakkō Kyōsai Kumiai Hō). Even when universal health insurance coverage was achieved in 1961, the basic structure of the health insurance system—public supervision but fragmented administration—remained intact.[94]

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Conclusion

It is a commonplace that World War II influenced society, the economy, and the politics of war participants. However, scholars tend to deal with the war as a black box, reluctant to theorize seriously about how, when, and to what degree the war affected these aspects of life. This book contributes to this broad question by focusing on the area of health insurance.

Before World War II, Japan and the United States were alike in that they had limited health insurance coverage. The war had a large impact on health insurance in both countries. Japan and the United States increased their health insurance coverage during World War II, and each consolidated its own health insurance system during the postwar reconstruction. Japan and the United States, however, adopted different health insurance systems during the stormy period of war and postwar reconstruction.

To understand the development of health insurance during the war and the postwar period, political scientists have paid more attention to the political structure, interest group politics, political culture, and preexisting policies. Of course the influence of these things cannot totally be denied. But this book has shown the other side of the story. World War II changed—created, abolished, and redefined—political institutions, interest groups, political culture, and policy as much as, if not far more than, the other way around. Furthermore, how the war advanced and how the war ended must be taken into account.

The Japan-U.S. comparison demonstrates not only that World War II boosted health insurance coverage but also that the kind of health insurance system adopted depended on each country's war experience. If the government

projected a rapid increase of mobilization and was not sure how long the war would last, the more that government preferred radical reform. The longer and deeper war mobilization became, the more power the government had at its disposal to realize its policy preferences. The timing of the rapid mobilization increase also affected what kind of policy the government could produce. If a long period of shallow mobilization preceded a rapid mobilization increase, the government had an easier time achieving radical reform.

As for the impact of the war on the postwar period, the more devastation a country suffered by the end of the war, the more likely it was that the government could justify its interventions in health insurance to ease postwar turmoil. Whether a country won or lost the war, furthermore, influenced the postwar health insurance politics in Japan and the United States in two ways. First, in the victorious United States, the American Medical Association could regain its political power by praising its contribution to the country's victory. The Japan Medical Association, by contrast, was blamed for its part in the war activities. Second, the lost war brought the U.S.-led military occupation to Japan. No legislative activity could be performed without the approval of the occupation authority. Furthermore, the military occupation provided a channel for the American domestic political battle over health insurance to come across the Pacific Ocean to affect the health insurance reform in Japan.

The findings from the cases of Japan and the United States await expansion to the other war participants. By treating World War II as a black box but rather by recognizing the existence of different wars and different postwar reconstructions for different countries, we should gain a new lens to interpret the development of health insurance in the other countries. Then we can have a better understanding of how, when, and how much World War II affected health insurance.

This project should promote new inquiries about how World War II influenced other social policies, such as cash assistance to the poor, old-age pensions, and unemployment policy. Based on the findings in this book, it would be natural to speculate that the war had a different impact on these policies than it did on health insurance. The war caused an economic boom, reduced poverty and unemployment, and mobilized the elderly and women into the workforce. Therefore, these policies have a less direct connection to the government's war activities than to health care policy. However, the former would gain more attention from the government to reconstruct the nation than the latter. World War II mobilized an unprecedented number of people in many countries. When the soldiers returned, the most urgent issue for the government was the increase

of unemployment and poverty. In such circumstances, health insurance might be a less important issue for the government than raising employment levels. Countries' different war experiences, moreover, might result in different policy outcomes.

Lastly, this book offers a normative implication. Health care policy should be considered a double-edged sword. The government can use health care policy not only to offer its people a better safety net but also to control their bodies and make them ready to fight in wars and kill others. Whenever the government talks about our health, we have to consider, "Health for whom and for what?"

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Notes

PREFACE

1. *Asahi Shimbun,* "Nara no Ninpu ga Shibō, Jūkyū no Byōin ga Tensō Kyohi, Rokujikan Hōchi" [A pregnant woman died, nineteen hospitals rejected the patient, she was left alone for six hours], October 17, 2006, available at www.asahi.com/kansai/news/OSK200610170022.html, accessed May 30, 2009.

2. For example, see *Yomiuri Shimbun,* "8 Byōin Kyohi, Ninpu Shibō" [Eight hospitals made rejections, a pregnant woman died], October 28, 2008, available at www.yomiuri.co.jp/iryou/news/iryou_news/20081028-OYT8T00224.htm, accessed May 30, 2009.

3. Prime Minister of Japan and His Cabinet, "Policy Speech Prime Minister Naoto Kan at the 174th Session of the Diet," available at www.kantei.go.jp/foreign/kan/statement/201006/11syosin_e.html, accessed June 29, 2010.

4. Barack Obama, "Remarks by the President in State of the Union Address," available at www.whitehouse.gov/the-press-office/remarks-president-state-union-address, accessed June 29, 2010.

INTRODUCTION

1. In this book, "World War II" means, for Japan, the Sino-Japanese War (1937–1945) between Japan and China and the Pacific War (1941–1945) between Japan and the Allied Powers; for the United States, it signifies the combat from 1941 to 1945.

2. This term, "health insurance system," includes activities in public and private health insurance as well as any lack of activities that result in uninsured citizens.

3. This is not to suggest that the postwar reconstruction of Japan and the United States ended in 1952, but that year was a watershed of the postwar recovery in both countries, as the following chapters show.

4. *Kōseirōdō Hakusho, White Paper of Health, Labour and Welfare,* 2007, 54–55, available at www.mhlw.go.jp/wp/hakusyo/kousei/07/dl/0102-c.pdf, accessed May 30, 2009.

5. U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2006,* available at www.census.gov/prod/2007pubs/p60-233.pdf, accessed February 29, 2008. The groups do not add up to 100% because some people have multiple kinds of health insurance.

6. Amenta, "What We Know," 92.

7. Steinmo and Watts, "It's the Institutions, Stupid!" See also Immergut, *Health Politics*.

8. On the relationship between congresspersons and their parties in the United States, see Jacobson, *Politics of Congressional Elections*.

9. Muramatsu and Krauss, "Bureaucrats and Politicians in Policymaking." On the industrial policy area, see Johnson, *MITI and the Japanese Miracle*.

10. Hacker, "Historical Logic of National Health Insurance," 72.

11. Ibid.

12. Katznelson, *City Trench*.

13. Pempel and Keiichi, "Corporatism without Labor?"

14. For example, see Hollingsworth, *Political Economy of Medicine*.

15. Mizuno, *Dare mo Kakanakatta Nihon Ishikai*.

16. Hartz, *Liberal Tradition in America*.

17. Tocqueville, *Democracy in America*, 509.

18. Lipset, *American Exceptionalism*, 31.

19. Hall, "Monarch for Modern Japan."

20. Lipset, *American Exceptionalism*, 212. For the cultural transformation in the formative period of modern Japan, see Gluck, *Japan's Modern Myths*; and Garon, *Molding Japanese Minds*.

21. Lipset, *American Exceptionalism*, 213.

22. Ibid., 253.

23. Pierson, "Not Just What but When," 75.

24. David, "Clio and the Economics of QWERTY."

25. Pierson, "Not Just What but When."

26. Hacker, *Divided Welfare State*.

27. Kawakami, *Gendai Nihon Iryōshi*. See also Adam D. Sheingate and Takakazu Yamagishi, "Occupation Politics: American Interests and the Struggle over Health Insurance in Postwar Japan," *Social Science History* 30, no. 1 (Spring 2006): 137–64.

28. Collier and Collier, *Shaping the Political Arena*.

29. Kasza, "War and Comparative Politics," 355. See also Kasza, *One World of Welfare*, ch. 2.

30. Shō, *Nihongata Fukushi Kokka no Keisei to Jūgonen Sensō*.

31. Mayhew, "War and American Politics"; and Katznelson and Shefter, eds., *Shaped by War and Trade*.

32. Titmuss, *Essays on the Welfare State*, 82. Another example of such work was Eckstein, *English Health Service*.

33. Kasza, "War and Comparative Politics," 357–58.

34. Shō, *Nihongata Fukushi Kokka no Keisei to Jūgonen Sensō*. Shō notes that there were some Japanese scholars who dealt with the relationship between war and social policy, such as Ōkouchi Kazuo, Kazahaya Yasoji, Kohashi Shōichi, and Takenaka Katsuo.

35. Shō, *Nihongata Fukushi Kokka no Keisei to Jūgonen Sensō*; and Kasza, "War and Welfare Policy in Japan."

36. Kryder, *Divided Arsenal*.

37. Klausen, *War and Welfare*.

38. Dryzek and Goodin, "Risk-Sharing and Social Justice."

39. Bensel, *Yankee Leviathan,* ch. 3.

40. Daniel Kryder also notes a possibility that the degree of war's devastation might have mattered to policy outcomes. By the summer of 1943, according to *The Crisis,* there was a "long war" argument, which was "currently debated wherever colored Americans gather and talk." Horace Cayton described it: "The graver the outside danger to the safety of this country, the more abundant the gains [for African Americans] will likely be." Kryder, *Divided Arsenal,* 15.

41. Titmuss, *Essays on the Welfare State,* 85.

42. Other recent works on war and social policy include the following: Dudziak, *Cold War Civil Rights*; Sparrow, *From the Outside in*; Light, *From Warfare to Welfare*; and Eisner, *From Warfare State to Welfare State*.

43. Lipset, *American Exceptionalism*.

44. Niki, *Iryōkeizai/Seisakugaku no Shiten to Kenkyu Hōhō*.

PART I: PREWAR DEVELOPMENT OF HEALTH INSURANCE

1. For Japan, the number does not include private health insurance coverage, which is considered to be a small percentage of the population. In detail, the public health insurance of Japan was as follows: the Health Insurance covered 4.9% and the National Public Service Mutual Aid Health Insurance 0.8%. Kōseishō Gojūnenshi Henshū Iinkai, *Kōseishō Gojūnenshi: Shiryō Hen,* 869–74. For the United States, the number includes for-profit private health insurance (4.6%) and nonprofit private health insurance (4.7%). Department of Commerce, Bureau of the Census, *Historical Statistics of the United States, Colonial Times to 1970,* 82. For Great Britain, see Great Britain, Central Statistical Office, *Statistical Abstract for the United Kingdom,* vol. 82 (London: His Majesty's Stationery Office, 1939), 5, 83.

2. Weissert and Weissert, *Governing Health,* 139.

CHAPTER 1: LEARNING FROM GERMANY

1. Kōseishō Gojūnenshi Henshū Iinkai, *Kōseishō Gojūnenshi: Kijutsu Hen,* 62. They rarely provided surgical procedures.

2. *Rangakui* usually studied under Dutch doctors in Dejima, which was an artificial island created by the Tokugawa Shogunate in Nagasaki Bay for the purpose of trading. Since the Tokugawa Shogunate adopted an isolationist policy that prohibited any interactions with foreign countries and foreigners without governmental permission, Dejima became the only place where Japanese people could become exposed to western culture. There were also doctors who studied Western-style medicine there. In the mid-sixteenth century, Christian missionaries brought Western-style medicine to Japan. Although the government continued to restrict the publication of translations of western books, doctors who were trained in Western-style medicine slowly grew. See Sakai, *Nihon no Iryōshi*; and Sugaya, *Nihon Iryō Seidoshi,* 3–4.

3. Quoted in Kawakami, *Gendai Nihon Iryōshi,* 122.

4. Ibid., 91.

5. Pyle, *Making of Modern Japan,* 65.

6. Kawakami, *Gendai Nihon Iryōshi,* 122.

7. Sons and apprentices of individual practitioners had been allowed to practice without passing the exam. Sugaya, *Nihon Iryō Seisakushi,* 39.

8. "Elite doctors" refer to those who were graduates from top medical schools at that time, such as Tokyo Imperial University and Keio University.

9. The law gave doctors an eight-year deferment period. Sugaya, *Nihon Iryō Seisakushi,* 101.

10. Kōseishō Gojūnenshi Henshū Iinkai, *Kōseishō Gojūnenshi: Kijutsu Hen,* 57. There were 28,262 medical doctors, of which 23,015 doctors specialized in Chinese medicine and 5,247 doctors practiced Western-style medicine.

11. Fuse, *Ishi no Rekishi,* 146.

12. Yoshihara and Wada, *Nihon Iryōhoken Seidoshi,* 24.

13. Clinics were smaller medical facilities than hospitals; the former had fewer than ten sickbeds.

14. Sugaya, *Nihon Iryō Seisakushi,* 38–42.

15. Sugaya, *Nihon Iryō Seidoshi,* 116–17. According to Sugaya, although there were no clear definitions for hospitals and clinics, it was speculated that hospitals were considered facilities that had the capacity to accommodate ten patients or more.

16. Kawakami, *Gendai Nihon Iryōshi,* 231–32. See also Steslicke, *Doctors in Politics,* 38. Although the regulations prevented doctors from being licensed exclusively in *Kanpō,* doctors were allowed to practice *Kanpō* as part of their treatment.

17. Kawakami, *Gendai Nihon Iryōshi,* 155.

18. Ibid., 242.

19. Ibid., 242; and Steslicke, *Doctors in Politics,* 42–43.

20. Steslicke, *Doctors in Politics,* 43.

21. Kawakami, *Gendai Nihon Iryōshi,* 352.

22. Sugaya, *Nihon Iryō Seisakushi,* 63–64. The members also received half of their wages after a four-day absence. Mutō Sanji was a Keio University graduate and went to the United States for three years. In 1921, he became the president of Kenebō, Ltd.

23. Ibid., 66–67. The mutual association of Ajin Mine, which was formed in 1888, was the first mutual association in Japan.

24. Ibid., 197. In 1928, 38% of doctors practiced in urban areas. By 1932, however, the percentage had changed to 55% urban, by 1936 to 58%.

25. Ibid., 199–201. On the role of the Industrial Cooperative Law in rural areas, see Sheingate, *Rise of the Agricultural Welfare State,* 67–70. Both Nitobe Inazō and Kagawa Toyohiko studied abroad, which influenced their social activism. Nitobe studied economics, history, and political science at the Johns Hopkins University from 1884 to 1887 and at the University of Halle-Wittenberg in Germany from 1887 to 1890. He is well known as the author of *Bushido*. Kagawa studied Christianity at Princeton University from 1914 to 1916.

26. Kawakami, *Gendai Nihon Iryōshi,* 45–46; and Sugaya, *Nihon Iryō Seidoshi,* 182–93.

27. Kawakami, *Gendai Nihon Iryōshi,* 33, 193. The Boshin War (1868–69) was fought between the Tokugawa Shogunate and the forces seeking to establish a new government. The Seinan War (1877) was the largest rebellion by descendents of the samurai class in the Meiji Era and the last instance of domestic warfare in Japan.

28. Sugaya, *Nihon Iryō Seidoshi,* 18; and Kōseishō Gojūnenshi Henshū Iinkai, *Kōseishō Gojūnenshi: Kijutsu Hen,* 141.

29. Sugaya, *Nihon Iryō Seisakushi,* 17.

30. Ibid., 216; and Keiichiro Hamaguchi, the Japan Institute for Labor Policy and Training, "Rōdōseisaku Repōto 7: Rōdō Shijō no Safety-net" [Labor policy report vol. 7: Safety net in the labor market], available at www.jil.go.jp/institute/rodo/2010/documents/007.pdf, accessed May 5, 2010.

31. Kawakami, *Gendai Nihon Iryōshi,* 222, 229, 348–49.

32. Shinpei Gotō, "Shippei no Hokenhō" [Sickness insurance], in *Nihon Shakaihoshō Zenshi Shiryō,* ed. Shakaihoshō Kenkyūsho, 6–12.

33. Sugaya, *Nihon Iryō Seisakushi,* 35.

34. Ibid., 36.

35. Kawakami, *Gendai Nihon Iryōshi,* 351.

36. Sugaya, *Nihon Iryō Seisakushi,* 67–70.

37. Ibid., 78–84.

38. In 1923 the restriction on the number of employees was reduced from fifteen to ten.

39. Kawakami, *Gendai Nihon Iryōshi,* 284–86; and Sugaya, *Nihon Iryō Seisakushi,* 92.

40. Kawakami, *Gendai Nihon Iryōshi,* 314.

41. Ibid., 314.

42. Pyle, *Making of Modern Japan,* 170; and Kasahara, *Nihon no Iryōgyōsei,* 81. On the party politics of this period, see Tipton, *Modern Japan,* 90–94.

43. Kawakami, *Gendai Nihon Iryōshi,* 353; Sugaya, *Nihon Iryō Seisakushi,* 115–119; Egi and Kataoka, "Shippeihoken Hōan ni tsuiteno Setsumei," 42–53; and Kōseishō Gojūnenshi Henshū Iinkai, *Kōseishō Gojūnenshi: Kijutsu Hen,* 316.

44. Kitahara, *Kenkōhoken to Ishikai,* 71. The Health Insurance Law initially designated 70% of doctors as Health Insurance Law practitioners, and each doctor had only 24 patients under the Health Insurance Law. Kawakami, *Gendai Nihon Iryōshi,* 357–58.

45. Kawakami, *Gendai Nihon Iryōshi,* 357.

46. Nomura, *Nihon Ishikai,* 29–31; and Kitahara, *Kenkōhoken to Ishikai,* 129.

47. Yamamoto, "Daijin no Aisatsu no Yōshi," 65.

48. Kōseishō, *Isei Hyakunen,* 222.

49. Kasahara, *Nihon no Iryōgyōsei,* 81.

50. The Mining Law was created in 1905 for mining industry workers. While the Factory Law passed in 1916, the Mining Law was amended to provide the same benefits as the Factory Law. See Sugaya, *Nihon Iryō Seisakushi,* 75–76.

51. For a brief summary of the Health Insurance Law, see Kitahara, *Kenkōhoken to Ishikai,* 3–20.

52. Sugaya, *Nihon Iryō Seisakushi,* 127–32.

53. Sakaguchi, *Nihon Kenkōhokenhō Seiritsushiron,* 177, 295.

54. Kitahara, *Kenkōhoken to Ishikai,* 166, 221.

55. Ibid., 228–31. When the Health Insurance Law was implemented, organized labor staged strikes against the Health Insurance Law (*kenpo suto*). They claimed that workers now had to pay premiums to get care for occupation-related sicknesses and injuries that the Factory Law and the Miners Law had covered for free. On the strikes, see also Kawakami,

Gendai Nihon Iryōshi, 33; Sugaya, *Nihon Iryō Seisakushi,* 132; Sakaguchi, *Nihon Kenkōhokenhō Seiritsushiron,* 9–10, 255; and Kōseishō Gojūnenshi Henshū Iinkai, *Kōseishō Gojūnenshi: Kijutsu Hen,* 527.

56. Sugaya, *Nihon Iryō Seisakushi,* 137.

CHAPTER 2: CATCHING UP WITH EUROPE

1. Starr, *Social Transformation of American Medicine,* 30–40.
2. Fishbein, *History of the American Medical Association,* 60.
3. Ibid., 45–46, 60, 102.
4. Starr, *Social Transformation of American Medicine,* 126. Non-MD practitioners included osteopaths, chiropractors, Christian Scientists, other faith healers, midwives, and chiropodists.
5. Anderson, *Health Services in the United States,* 58.
6. Starr, *Social Transformation of American Medicine,* 113.
7. Fishbein, *History of the American Medical Association,* 19.
8. American Medical Association, "Our Founder, Nathan Davis Smith," available at www.ama-assn.org/ama/pub/about-ama/our-history/the-founding-of-ama/our-founder-nathan-smith-davis.shtml, accessed May 30, 2009.
9. Starr, *Social Transformation of American Medicine,* 90; American Medical Association, *Caring for the Country,* 13.
10. Kaufman, *American Medical Education,* 127–30.
11. Starr, *Social Transformation of American Medicine,* 114.
12. Ibid., 115–16.
13. Ibid., 117–18; and Anderson, *Health Services in the United States,* 58. For more detailed information about the AMA's involvement of medical education at this period, see "Illustrated Highlights," available at www.ama-assn.org/ama/pub/about-ama/our-history/illustrated-highlights/1900-1939.shtml, accessed May 30, 2009.
14. Kaufman, *American Medical Education*.
15. Numbers, *Almost Persuaded,* 27; and Starr, *Social Transformation of American Medicine,* 273.
16. Starr, *Social Transformation of American Medicine,* 273; and Morone, *Democratic Wish,* 255. There were, however, two major dissenting physicians' groups that emerged by the 1940s: the socialist American League for Public Medicine and the liberal academia-based Committee of Physicians for the Improvement of Medicine, although both were far less influential than the AMA. Starr, *Social Transformation of American Medicine,* 274.
17. "The American Medical Association: Power, Purpose, and Politics in Organized Medicine Source," *Yale Law Journal* 63, no. 7 (May 1954): 954.
18. George, *Progress and Poverty.*
19. Nicklason, "Henry George," 654.
20. Dobbin, "Origins of Private Social Insurance," 1417.
21. Becker, "Organized Labor," 122.
22. Hacker, *Divided Welfare State,* 202.

23. Starr, *Social Transformation of American Medicine,* 198–99.

24. Ibid., 203. This contract practice expanded until the 1920s, but it declined quickly during the Great Depression in the 1930s. The Great Depression led the companies to shift risk to third parties; the insurance companies and nonprofit organizations expanded by offering group health benefits. See also Hacker, *Divided Welfare State,* 201.

25. Fishbein, *History of the American Medical Association,* 385.

26. Ibid., 332.

27. Starr, *Social Transformation of American Medicine,* 209–15.

28. Ibid., 301–2.

29. Ibid., 304–5.

30. Ibid., 305.

31. Ibid.

32. Ibid., 295–96.

33. Hacker, *Divided Welfare State,* 204.

34. Ibid., 203.

35. The AHA was established by eight hospital superintendents in 1899 for "the promotion of economy and efficiency in hospital management." On the AHA, see Lesparre, "Century of the AHA," 38–49.

36. Hacker, *Divided Welfare State,* 204. The AHA was far less influential than the AMA at that time. Anderson, *Health Services in the United States,* 124.

37. Starr, *Social Transformation of American Medicine,* 297–99; and Hacker, *Divided Welfare State,* 205.

38. Hacker, *Divided Welfare State,* 202.

39. Anderson, *Health Services in the United States,* 123; and Starr, *Social Transformation of American Medicine,* 298.

40. Anderson, *Health Services in the United States,* 124.

41. Starr, *Social Transformation of American Medicine,* 308.

42. Ibid.

43. Anderson, *Health Services in the United States,* 125.

44. Starr, *Social Transformation of American Medicine,* 305–6.

45. Hacker, *Divided Welfare State,* 215.

46. Starr, *Social Transformation of American Medicine,* 306.

47. Poen, *Harry S. Truman Versus the Medical Lobby,* 15.

48. Parsons, "Social Change and Medical Organization," 32.

49. Starr, *Social Transformation of American Medicine,* 240; and U.S. Public Health Service, *History, Mission, and Organization of the Public Health Service,* 1.

50. Anderson, *Health Services in the United States,* 27, 43–44.

51. Ibid., 44.

52. Jensen, *Patriots, Settlers,* 48–49.

53. Skocpol, *Protecting Soldiers and Mothers,* 140.

54. Hines, "Medical Care Program of the Veterans Administration," 74.

55. Magnuson, "Medical Care for Veterans," 76–77; and Hines, "Progress of the Part," 115.

56. Hines, "Veterans' Administration and National Defense," 76.

57. Anderson, *Health Services in the United States,* 44.

58. Magnuson, "Medical Care for Veterans," 76.

59. Starr, *Social Transformation of American Medicine,* 260. The Sheppard-Towner Act was named after Senator Morris Sheppard (D-Texas) and Representative Horace Mann Towner (R-Iowa).

60. Anderson, *Health Services in the United States,* 44–45; and Rinehart, "Maternal Health Care Policy," 196.

61. Anderson, *Health Services in the United States,* 47.

62. Starr, *Social Transformation of American Medicine,* 260; and Skocpol, *Protecting Soldiers and Mothers,* 511.

63. Skocpol, *Protecting Soldiers and Mothers,* 500. See also Kessler-Harris, *In Pursuit of Equity.*

64. Anderson, *Health Services in the United States,* 66.

65. Poen, *Harry S. Truman Versus the Medical Lobby,* 252. See also Hacker, *Divided Welfare State,* 197.

66. Quoted in Steinmo and Watts, "It's the Institutions, Stupid!" 338.

67. Starr, *Social Transformation of American Medicine,* 243.

68. Ibid., 243; and Anderson, *Health Services in the United States,* 67. The AALL's membership was small and mainly academic, and it included John R. Commons and Richard Ely of the University of Wisconsin and Henry R. Seager of Columbia University. The AALL's main initial concern was occupational diseases and the promotion of workmen's compensation laws. It also sought legislation prohibiting child labor, unemployment relief through public works, and unemployment insurance. The AALL expanded its membership from 165 in 1906 to a peak of over 3,300 in 1913.

69. Anderson, *Health Services in the United States,* 70.

70. Starr, *Social Transformation of American Medicine,* 246; and Anderson, *Health Services in the United States,* 89.

71. Quoted in Anderson, *Health Services in the United States,* 74.

72. Starr, *Social Transformation of American Medicine,* 246; Fishbein, *History of the American Medical Association,* 286; and Numbers, *Almost Persuaded,* 113. In contrast to many reformers at that time, Rubinow believed that the United States could skip the phase of private insurance development and immediately establish a public insurance program. Anderson, *Health Services in the United States,* 69.

73. Starr, *Social Transformation of American Medicine,* 260.

74. Morone, *Democratic Wish,* 256.

75. Fishbein, *History of the American Medical Association,* 321; and Anderson, *Health Services in the United States,* 79; and Hacker, "Historical Logic of National Health Insurance," 111–12. Jacob Hacker also argues that America's entry into World War I had a negative influence on the reformers. He concludes, "Perhaps if the war had not interceded, the AALL campaign would have fared better." His argument is right in that America's actual experience in World War I had a negative impact on the development of national health insurance. But this should not be confused with the argument that war always has a negative influence on the government's intervention in health insurance. In his presidential address at the 1916 annual AALL meeting, Irvin Fisher indicated the positive effect of health insurance on war

mobilization by stating that health insurance greatly contributed to decreasing poverty and death rates and the increasing number of physically fit soldiers. Although the actual history did not come to pass as Fisher expected, his words suggest a hypothesis that a different kind of war might result in promoting health insurance. Hacker, "Historical Logic of National Health Insurance," 111; and Anderson, *Health Services in the United States,* 72.

76. Fishbein, *History of the American Medical Association,* 501.

77. Quoted in Skocpol, *Protecting Soldiers and Mothers,* 513.

78. Starr, *Social Transformation of American Medicine,* 260; Anderson, *Health Services in the United States,* 48; and Hacker, "Historical Logic of National Health Insurance," 113. Rinehart argues that the Sheppard-Towner Act drastically improved the quality of maternal and infant health conditions. Rinehart, "Maternal Health Care Policy," 196.

79. Fishbein, *History of the American Medical Association,* 374.

80. Ibid., 384.

81. Poen, *Harry S. Truman Versus the Medical Lobby,* 15; and Starr, *Social Transformation of American Medicine,* 267.

82. Morone, *Democratic Wish,* 257; and Steinmo and Watts, "It's the Institutions, Stupid!" 339.

83. Anderson, *Health Services in the United States,* 113; and Starr, *Social Transformation of American Medicine,* 275.

84. Nelson, "Social Security Administration," 493; Derickson, "Health Insurance for All?" 1337; and Marmor, *Politics of Medicine,* 9. The Social Security Board became the Social Security Administration in 1946. The National Security Agency was the precursor of the Department of Health, Education, and Welfare, which was established in 1953, and the Department of Health and Human Services, as it was called after 1979.

85. Starr, *Social Transformation of American Medicine,* 266; and Derickson, "Health Insurance for All?" 1338. The labor organizations realized that they could not provide workers' benefits by themselves. They sent fifteen delegations, the second largest group. The health care providers sent the largest delegation.

86. Derickson, *Health Security for All,* 84.

87. The FSA was the precursor of the Department of Health, Education, and Welfare (1953–1979).

88. U.S. Public Health Service, *History, Mission, and Organization of the Public Health Service,* 2.

89. Starr, *Social Transformation of American Medicine,* 269; and Hirshfield, *Lost Reform,* 145–51.

90. Klem, "Some Recent Developments," 14.

91. Starr, *Social Transformation of American Medicine,* 271. Fumiaki Kubo indicates that Henry Wallace, the secretary of agriculture, paid special attention to the poor conditions of the farmers, and the Farm Security Administration produced policies that were some of the greatest achievements of the New Deal. Kubo, *Nyūdīru to Amerika Minshusei,* 152–77.

92. Starr, *Social Transformation of American Medicine,* 64. Regional inequality and the availability of physicians had been increasing since the Civil War. An AMA study showed that more than a third of small towns that had physicians in 1914 had lost them by 1925. Ibid., 125.

93. Ibid., 271.

94. Klem, "Some Recent Developments," 5.

PART II: HEALTH SECURITY AS NATIONAL SECURITY

1. Titmuss, *Essays on the Welfare State,* 82–83.

2. Pierson, "Not Just What but When," 75.

CHAPTER 3: CREATING A PUBLIC HEALTH INSURANCE SYSTEM

1. Shō Kashin's work is an example of the study of Japanese social security policy. The title of his book *Nihongata Fukushi Kokka no Keisei to Jūgonen Sensō* translates as, "The Fifteen-Year War and the Formation of Japanese Welfare State."

2. Sugaya, *Nihon Iryō Seisakushi,* 39.

3. Kōseishō Gojūnenshi Henshū Iinkai, *Kōseishō Gojūnenshi: Kijutsu Hen,* 375.

4. Quoted in Tatara, *1400 Years of Japanese Social Work.*

5. Quoted in Kashin, *Nihongata Fukushi Kokka no Keisei to Jūgonen Sensō,* 46.

6. Koizumi was born the third son of Koizumi Chikamasa, a medical doctor in the Army, in Fukui Prefecture in 1884. He earned a B.A. from Tokyo Imperial University in 1908 and a Ph.D. in medicine in 1921. From March 1934 to December 1938, he headed the army's medical bureau. He became minister of health and welfare in July 1941 and remained in the position until July 1944. He committed suicide in September 1945. Kenkyūkai, ed., *Nihon Rikukaigun no Seido, Soshiki, Jinji,* 29.

7. Kōseishō Gojūnenshi Henshū Iinkai, *Kōseishō Gojūnenshi: Kijutsu Hen,* 379. Konoe resigned from the cabinet in January 1939, but he remained politically influential and again served as prime minister from July to October 1940. He traced his genealogy back to the imperial family.

8. Kawakami, *Gendai Nihon Iryōshi,* 428; and Kōseishō Gojūnenshi Henshū Iinkai, *Kōseishō Gojūnenshi: Kijutsu Hen,* 342, 380. Under the Meiji Constitution, resignation from the cabinet had to take place if all the cabinet members did not agree.

9. Tatara, *1400 Years of Japanese Social Work,* 186.

10. Kōseishō Gojūnenshi Henshū Iinkai, *Kōseishō Gojūnenshi: Kijutsu Hen,* 343.

11. The Social Affairs Bureau was created in August 1920 and reorganized as an external ministerial agency in the Home Ministry in November 1922.

12. Kurosawa, *Taisenkanki no Nihon Rikugun,* 390. The precedents of the Board of Planning were the Cabinet Investigation Bureau (*Naikaku Chōsa Kyoku*) and the Planning Bureau (*Kikaku Kyoku*), which were established in 1935 and 1937, respectively.

13. Uemura, "Genka Senji Taisei no Gaiyō," 12.

14. Ikuta, *Nihon Rikugunshi,* 165.

15. "Kōseishō no Kaisetsu" [Opening of the Ministry of Health and Welfare], *Yomiuri Shimbun,* January 11, 1938.

16. Kōseishō Nijūnenshi Henshū Iinkai, *Koseishō Nijūnenshi,* 118.

17. Takei, *Kōseishō Shōshi,* 3. See also Yamazaki, "Relief Measures for Soldiers' Families," 673; and Miura, *Rōdō to Kenkō no Rekishi,* 383.

18. The Board of Military Protection (Engo Kyoku) was separated from the Bureau of Social Affairs as an external ministerial agency in July 1939. The Board of Insurance was reorganized as an internal ministerial agency in November 1942.

19. Tatara, *1400 Years of Japanese Social Work*, 188–90.

20. Shō, *Nihongata Fukushi Kokka no Keisei to Jūgonen Sensō*, 61–62.

21. "Gojūhachi no Dokushinsha: 'Kano da . . .': Koizumi Shin Kōshō" [Fifty-eight-year-old single man: Koizumi, new minister of health and welfare], *Yomiuri Shimbun*, July 19, 1941.

22. Koizumi, *Kokumin Tairyoku no Genjō wo Nobe Kokumin no Funki wo Nozomu*, 4–5.

23. Nihon Ishikai [Japan Medical Association], "Enjo no engo wo mezashite: Zenkoku Ishikai iryōhōkoku ni maishin" [To support the behind-the-gun activities: Prefectural medical associations strive for national service], *Nihon Ishikai Zasshi* [Journal of the Japan Medical Association] 12, no. 12 (August 1937): 32.

24. Ibid.

25. Nihon Ishikai [Japan Medical Association], "Kantōgen: Jūgojin toshiteno seishinteki yōi" [Preface: To develop our mind to support the behind-the-gun activities], *Nihon Ishikai Zasshi* [Journal of the Japan Medical Association] 13, no. 2 (October 1937): 1.

26. Nihon Ishikai [Japan Medical Association], "Kantōgen: Kōseisho no ganbō" [Preface: A view of the Ministry of Health and Welfare], *Nihon Ishikai Zasshi* [Journal of the Japan Medical Association] 13, no. 5 (January 1938): 1.

27. Kōseishō Gojūnenshi Henshū Iinkai, *Kōseishō Gojūnenshi: Kijutsu Hen*, 353–54.

28. The Ministry of Agriculture and Forestry (Nōrinshō) surveyed economic conditions in rural areas and found them horrible. One bureaucrat sent to Iwate Prefecture found that the poor farmers who could not borrow money had to sell their daughters into prostitution for between two and three yen. "Nigirimeshi Ubaiau Jidō: Yamano Kaju ha Marubōzu" [Fighting for rice: No fruit on the mountain], *Tokyo Asahi Shimbun*, June 7, 1932.

29. Kōseishō Gojūnenshi Henshū Iinkai, *Kōseishō Gojūnenshi: Kijutsu Hen*, 91.

30. Sugaya, *Nihon Iryō Seisakushi*, 189.

31. Kawakami, *Gendai Nihon Iryōshi*, 419.

32. Suzuki, "Kokumin Kenkōhoken Seido Yōkōan ni taisuru Ichi Kōsatsu," 114–15.

33. Kōseishō Hoken Kyoku Kokumin Kenkōhoken Ka and Kokumin Kenkōhoken Chūō Kai, *Kokumin Kenkōhoken Yonjūnenshi*, 4.

34. Hirose Hisatada, "Shakaihuan wo Nozoku Shakaiseisaku wo" [The establishment of social policy to eliminate social uncertainty], in Kōseishō Nijūnenshi Henshū Iinkai, *Koseishō Nijūnenshi*, 4.

35. "Donzoko no Nōmin Kyūsai: Kyūbō ni Mikanete Rikugun mo Tsuini Tatsu" [Relieving farmers: The Ministry of War finally gets involved in the relief project], *Yomiuri Shimbun*, June 7, 1932.

36. Ōe, *Chōheisei*.

37. Koizumi, "Hoken Kokusaku no Konpon Mondai," 7.

38. Kawakami, *Gendai Nihon Iryōshi*, 423.

39. Quoted in Kōseishō Gojūnenshi Henshū Iinkai, *Kōseishō Gojūnenshi: Kijutsu Hen*, 524.

40. Sugaya, *Nihon Iryō Seisakushi*, 193–202.

41. Saguchi, *Kokumin Kenkōhoken*, 23; and Sugaya, *Nihon Iryō Seisakushi*, 202.

42. Kawakami, *Gendai Nihon Iryōshi,* 419; Saguchi, *Kokumin Kenkōhoken,* 71; and "Kokumin Hoken Hōan," *Shūgiin Giji Sokkiroku* 70, part 1 (Tokyo: Tokyo University Press, 1984), 146. The JMA's strategy reveals that medical associations favored national health insurance over a certain private health insurance.

43. Quoted in Saguchi, *Kokumin Kenkōhoken,* 69.

44. Yoshihara and Wada, *Nihon Iryōhoken Seidoshi,* 80.

45. Kido, "Shukuji," 15.

46. Shindō, "Nentō no Ji," 1.

47. "Shokuin Kenkōhoken Hōan" [White-Collar Health Insurance Bill], *Shūgiiin Giji Sokkiroku,* vol. 72, part 1 (Tokyo: Tokyo University Press, 1985), 413.

48. Kawakami, *Gendai Nihon Iryōshi,* 440–41. See also Kōseishō Gojūnenshi Henshū Iinkai, *Kōseishō Gojūnenshi: Kijutsu Hen,* 363, 529–32.

49. When health insurance was discussed in the House of Peers, the House imposed a condition to commission a study about a social security program for seamen. Kōseishō Gojūnenshi Henshū Iinkai, *Kōseishō Gojūnenshi: Kijutsu Hen,* 534.

50. "Sen-in Hoken Hōan" [Seamens' Insurance], *Shūgiin Giji Sokkiroku* 72, part. 1 (Tokyo: Tokyo University Press 1939), 564. The formation of the Seamen's Insurance had a longer history than the White-Collar Workers' Health Insurance. Sugaya, *Nihon Iryō Seisakushi,* 204.

51. Kōseishō Gojūnenshi Henshū Iinkai, *Kōseishō Gojūnenshi: Kijutsu Hen,* 363, 536–37.

52. Sugaya, *Nihon Iryō Seisakushi,* 216.

53. Ibid., 216–17.

54. Kōseishō Gojūnenshi Henshū Iinkai, *Kōseishō Gojūnenshi: Kijutsu Hen,* 483–84.

55. The numbers for the period between 1933 and 1936 are not available.

56. Takei, *Kōseishō Shōshi,* 91; and Kōseishō Gojūnenshi Henshū Iinkai, *Kōseishō Gojūnenshi: Kijutsu Hen,* 422.

57. Kawakami, *Gendai Nihon Iryōshi,* 449–51. In 1929, the number of doctorless villages was 2,909; in 1936 the number increased to 3,243 and in 1939 to 3,600 (about one-third of all municipalities).

58. Nihon Ishikai [Japan Medical Association], "Kantōgen: Kasanete iryō kōei shian ni hantaisu" [Preface: To oppose a plan to put the medical system under public management], *Nihon Ishikai Zasshi* [Journal of the Japan Medical Association] 14, no. 5 (January 1939): 1.

59. Kawakami, *Gendai Nihon Iryōshi,* 438–39.

60. In 1937, private doctors owned about 95% of all hospitals. Kōseishō Gojūnenshi Henshū Iinkai, *Kōseishō Gojūnenshi: Kijutsu Hen,* 350.

61. Quoted in Nomura, *Nihon Ishikai,* 45–46.

62. Kawakami, *Gendai Nihon Iryōshi,* 446. The National Dominant Hereditary Law was an example of the totalitarian elements of wartime health care legislation. While the government prohibited abortions and encouraged births, it legalized abortions for those who were considered genetically inferior.

63. Sugaya, *Nihon Iryō Seisakushi,* 200.

64. Kawakami, *Gendai Nihon Iryōshi,* 453.

65. Kōseishō Gojūnenshi Henshū Iinkai, *Kōseishō Gojūnenshi: Kijutsu Hen,* 423; Takei, *Kōseishō Shōshi,* 91–97; and Kawakami, *Gendai Nihon Iryōshi,* 454. By this measure, the gov-

ernment gave the Japan Medical Corporation one million yen for five years, and the municipalities could contribute to building hospitals. Kawakami, *Gendai Nihon Iryōshi,* 456.

66. Quoted in Kawakami, *Gendai Nihon Iryōshi,* 452.

67. Quoted in Nomura, *Nihon Ishikai,* 45–46.

68. Kawakami, *Gendai Nihon Iryōshi,* 484.

69. Tipton, *Modern Japan,* 130–31. See also "Taisei Yokusankai (Imperial Rule Assistance Association)," *Modern Japan in Archives,* available at www.ndl.go.jp/modern/e/cha4/description12.html, accessed May 24, 2010.

70. Kawakami, *Gendai Nihon Iryōshi,* 453. Taniguchi was later president of the JMA from 1950 to 1952. For the development of state-initiated mass organizations, see Kasza, *Conscription Society.*

71. Kawakami, *Gendai Nihon Iryōshi,* 456; and Nomura, *Iryō to Kokumin Seikatsu,* 91–92.

72. "Ishikai Shintaisei Kimaru: Seihu no Kenmin Seisaku ni Kyōryoku" [Change of the medical associations: Making them cooperate with the government, *Yomiuri Shimbun,* August 19, 1942.

73. Miwa, *Mōi Takemi Taro,* 171. Fukuzawa was the founder of Keio University, which was a private university and sought to be a private counterpart of the University of Tokyo. Fukuzawa cooperated with Kitazato to develop studies of infectious diseases in Japan. When the medical school of Keio University was created, Kitazato became its first dean. Kitazato was also the first president of the JMA, serving from 1916 to 1931. Kitajima served as the second president of the JMA, from 1931 to 1943. He was born in Ishikawa Prefecture and studied in Germany from 1930 to 1934. On the history of the Japan Medical Association, see Nihon Isikai Sōritsu Gojusshūnen Kinen Jigyō Suishin Iinkai, *Nihon Ishikai Sōritsu Kinenshi.*

74. Katō, *Chōheisei to Kindai Nihon,* 240.

75. Hirai, "Nento no Ji," 2–3.

76. Zaitsu, "Kenkōhoken no Shinshimei to Hoken-i heno Yōbō," 1–4.

77. Kawakami, *Nihon Iryō Seisakushi,* 440–41.

78. Kōseishō Gojūnenshi Henshū Iinkai, *Kōseishō Gojūnenshi: Kijutsu Hen,* 361. The Health Insurance Law amendment of 1942 was phased in on April 1, 1942, January 1, 1943, and April 1, 1943.

79. Kasza, "War and Welfare Policy in Japan," 424.

80. Saguchi, "Kokumin Kenkōhoken to Iryō no Shakaika," 6.

81. Sugaya, *Nihon Iryō Seisakushi,* 201.

82. Kōseishō Gojūnenshi Henshū Iinkai, *Kōseishō Gojūnenshi: Kijutsu Hen,* 546–47; and Tatara, *1400 Years of Japanese Social Work,* 189.

83. Kōseishō Gojūnenshi Henshū Iinkai, *Kōseishō Gojūnenshi: Kijutsu Hen,* 552–53.

84. Quoted in Sugaya, *Nihon Iryō Seisakushi,* 266.

CHAPTER 4: FORMING A HYBRID HEALTH INSURANCE SYSTEM

1. Roosevelt, "December 7, 1941," 514.

2. Quoted in Brinkley, *End of Reform,* 180.

3. Ibid., 180–81.

4. Office of Management and Budget, "Table 6.1: Composition of Outlays: 1940–2015," available at www.whitehouse.gov/omb/budget/Historicals/, accessed September 13, 2010.

5. Rowntree, "Fit to Fight," 30.

6. Flynn, *Mess in Washington,* 188; and Selective Service System, *Selective Service at Work in Peacetime,* 122. For details of the Victory Program, see Mark S. Watson, *Chief of Staff: Prewar Plans and Preparations* (Washington, DC: Center of Military History, United States Army, 1991), available at www.army.mil/cmh-pg/books/wwii/csppp/, accessed May 30, 2009.

7. Social Security Board, *Fifth Annual Report,* 145.

8. Ibid., 20.

9. U.S. Senate, Committee on Education and Labor, "Report of Subcommittee of Senate Education and Labor Committee on S. 2871," 3–4.

10. Brinkley, *End of Reform,* 181–83.

11. Selective Service System, *Selective Service in Wartime,* 109.

12. Quoted in Selective Service System, *Selective Service at Work in Peacetime,* 659.

13. Ibid., 659. Paul McNutt was elected governor of Indiana in 1932 and briefly competed with Roosevelt for the Democratic president nomination in 1936.

14. Flynn, *Mess in Washington,* 39.

15. Rowntree, "Fit to Fight," 31.

16. Ibid., 47.

17. Bloomfield, "Influence of War on Industrial Medicine," 563.

18. Selective Service System, *Selective Service in Wartime,* 355.

19. Ibid., 360. The full text can be found in Selective Service System, *Selective Service at Work in Peacetime,* 672–74.

20. Under the leadership of Stimson and Knox, the Department of War and the Department of the Navy strengthened their capacity to "win control over industrial production and bend virtually the entire American economy to their needs." Brinkley, *End of Reform,* 186.

21. Flynn, *Mess in Washington,* 80–81.

22. Ibid., 189.

23. Charles E. Martz, "Town Meeting Preview: Should Civilians be Drafted for National Service?" *Town Meeting* 9, no. 40 (1943): 22, in Record Group (RG) 47, Records of the Social Security Administration, Records of the Office of the Commissioner, Speeches and Articles, 1946–1950, box 4-Articles, National Archives, College Park, Maryland (hereafter NACP).

24. Flynn, *Mess in Washington,* 89.

25. Fishbein, "Doctors at War," 4. The AMA's membership was 120,701 in April 1, 1942. See "Course of Events: American Medical Association," *Medical Care: Economic and Social Aspects of Health Service* 2, no. 3 (1942): 272. *Medical Care* was published by the Committee on Research in Medical Economics.

26. "Course of Events: The Federal Scene," *Medical Care* 2, no. 3 (July 1942): 267; and Michael M. Davis, "Doctors Where We Need Them" 1942, p. 4. In RG 47, Records of the Social Security Administration, Records of the Office of the Commissioner, Speeches and Articles, 1946–1950, box 1-095, NACP.

27. Perrott and Davis, "War and the Distribution of Physicians," 2.

28. "Course of Events: Health Defense," *Medical Care* 2, no. 1 (1942): 66.

29. Davis, "Doctors Where We Need Them," 9; and "Course of Events: American Medical Association," *Medical Care* 2, no. 3 (1942): 271.

30. Eliot, "Maternity Care for Service Men's Wives," 113.

31. Ibid., 114; and Rinehalt, "Maternal Health Care Policy," 199.

32. Eliot, "Maternity Care for Service Men's Wives," 114; Anderson, *Health Services in the United States,* 119; Adler, "Medical Care for Dependents of Men"; Bruce, "Government Provides Maternity Aid for Service Men's Wives," 133–36; and Lindenmeyer, *Right to Childhood,* 242. Maternity care occupied 95% of payments. "Editorials: Obsteric and Pediatric Car of Wives and Infants of Enlisted Men," *Journal of the American Medical Association* 122, no. 18 (August 1943): 1251.

33. "Course of Events: The Federal Scene," *Medical Care* 2, no. 4 (1942): 368.

34. Eliot, "Maternity Care for Service Men's Wives," 114.

35. Mulligan, *Three Federal Interventions,* 25.

36. Anderson, *Health Services in the United States,* 17.

37. Hines, "Veterans' Administration and National Defense," 25.

38. "News, Notes, and Discussion: Acceleration of Hospital Construction," *Medical Bulletin of the Veterans Administration* 19 (January 1943): 359–40."

39. Clark, "Limits of State Autonomy," 257–66. For details on the program, see U.S. Senate, "Experimental Health Program of the United States Department of Agriculture."

40. American Medical Association, "Editorials," *Journal of the American Medical Association* 122, no. 18 (1943):1252.

41. Clark, "Limits of State Autonomy," 264.

42. U.S. Department of Commerce, Bureau of the Census, "Persons Covered by Private Health Insurance for Hospital and Surgical Benefits: 1939–1970," *Historical Statistics of the United States, Colonial Times to 1970,* part 1, 82.

43. Brinkley, *End of Reform,* 210.

44. Hacker, *Divided Welfare State,* 218.

45. Baker and Dahl, *Group Health Insurance and Sickness Benefits Plans,* 16; Becker, "Organized Labor," 95, 123; Gordon, "Why No National Health Insurance in the U.S.?" 297; Hacker, "Historical Logic of National Health Insurance," 115; and Derickson, "Health Insurance for All?" 1344.

46. Baker and Dahl, *Group Health Insurance and Sickness Benefits Plans,* 16.

47. Dobbin, "Origins of Private Social Insurance," 1416.

48. Starr, *Social Transformation of American Medicine,* 321. Ten years after the war, the Kaiser Permanente health plan had a half million people enrolled. See also Anderson, *Health Services in the United States,* 18–19.

49. Kruif, *Kaiser Wakes the Doctors,* 151.

50. Starr, *Social Transformation of American Medicine,* 306.

51. Michael M. Davis, "Letter to Harry Hopkins," July 10, 1940, RG 47, Records of the Social Security Administration, 1946–1950, box 1-4, NACP, 3–4.

52. Michael M. Davis, "Letter to Sidney Hillman," July 30, 1940, RG 47, Records of the Social Security Administration, 1946–1950, box 2-095, NACP.

53. Michael M. Davis, "Letter to Isidore S. Falk," January 20, 1941, RG 47, Records of the Social Security Administration, 1946–1950, box 1-095, NACP.

54. Roosevelt, "Address at the Dedication of the National Institute of Health, Bethesda, Maryland," 525, 528.

55. "Guns and Health," *New York Times,* August 18, 1940.

56. "One-Fourth of Men Called Here Found Unfit for the Army Service: Rejections for Physical Reasons May Summon Those Far Down on Lists of the Board—Teeth and Eyesight Chief Faults," *New York Times,* November 27, 1940.

57. "Third of Draftees Physically Unfit," *New York Times,* January 27, 1941.

58. "Social Security and National Defense: An Address by Arthur Altmeyer, Chairman, Social Security Board, at the Fourteenth Annual National Conference of the American Association for Social Security," April 5, 1941, 6, RG 47, Records of the Social Security Administration, 1946–1950, box 4-speech, NACP.

59. Olin West, "Letter to Paul V. McNutt," June 27, 1941, RG 47, Records of the Social Security Board, Central File, 1935–1947, box 60-056.1, NACP.

60. Paul V. McNutt, "Letter to Olin West," July 12, 1941, RG 47, Records of the Social Security Board, Central File, 1935–1947, box 60-056, NACP.

61. William Green, "Letter to John H. Tolan," July 28, 1941, 2, RG 47, Records of the Social Security Board, Central File, 1935–1947, box 60-056, NACP.

62. Social Security Board, *Sixth Annual Report,* 26.

63. "Army 'Reject' Ratio Alarms President: Roosevelt Thinks Draft Figures Show Health of Nation in a Bad Condition," *New York Times,* October 4, 1941.

64. "Dentistry to Cut Rejections," *New York Times,* December 2, 1941; and Poen, *Harry S. Truman Versus the Medical Lobby,* 30.

65. The reasons for the rejection varied, but most of them were because of physical defects. Out of the first million rejectees, about 90% were rejected for physical defects and about 10% for illiteracy. Fishbein, "Doctors at War," 8.

66. The armed forces, for example, lowered their standards for those who had dental defects in order to increase the number of acceptable draftees. Rowntree, "Fit to Fight," 36.

67. Selective Service System, *Selective Service as the Tide of War Turns,* 173.

68. Rowntree, "Fit to Fight," 48.

69. Quoted in Michael M. Davis, "How Healthy Are We?" *New York Times*, February 22, 1942, 11.

70. Davis, "How Healthy Are We?" 11.

71. Stein, "Fundamental Programs," 10.

72. Selective Service System, *Selective Service in Wartime,* 86.

73. Quoted in Davis, "How Healthy Are We?" 37.

74. Falk, "Mobilizing for Health Security," 70–71. Falk also indicated that hospitals, registered by the AMA from 1937 to 1941, increased by 230 and the number of beds by nearly 200,000, but most of the hospitals were not available to non-military-related personnel. See also "Physicians Shortage Becomes Issue on Capitol Hill: Alarmed by Epidemic Hazard, Congressmen Demand Action," *Medical Economics* 20, no. 3 (1942): 32–33, 96–108; and "Doctors Wants a U.S. Agency to Allot Medical Manpower," *New York Times,* July 6, 1943.

75. Falk, "Mobilizing for Health Security," 69.

76. Ibid., 74.

77. Cohen, "Next Steps and Future Goals," 41–42.

78. Kingsley Roberts, "Analysis of the Current Situation in the Field of Medico-Socio-Economics," RG 47, Records of the Social Security Administration, 1946–1950, NACP. Michael

Davis's handwritten note, attached to this report, shows that Davis circulated Roberts's analysis to Altmeyer and Falk.

79. Roberts, "Analysis of the Current Situation."

80. Wilbur J. Cohen, "Letter to Dan Goldy," December 21, 1942, RG 47, Records of the Social Security Board, Central File, 1935–1947, box 60-056.1, NACP.

81. Social Security Board, "Social Security for Great Britain," 30.

82. "Labor for Victory," NBC–WRC, Washington, D.C., 1:15 to 1:30 p.m., June 6, 1943, 3. RG 47, Records of the Social Security Administration, 1946–1950, box 4-Articles, NACP; and "Wagner-Murray-Dingell Social Security Plan," *Journal of the American Medical Association* 122, no. 9 (June 1943): 609.

83. Poen, *Harry S. Truman Versus the Medical Lobby,* 32.

84. Wilbur Cohen later drafted the Medicare Act of 1965 and became secretary of health, education, and welfare under President Lyndon B. Johnson.

85. Poen, *Harry S. Truman Versus the Medical Lobby,* 33. See also Berkowitz, *Mr. Social Security,* 49–52.

86. Poen, *Harry S. Truman Versus the Medical Lobby,* 32; and Starr, *Social Transformation of American Medicine,* 280.

87. The WMD bill planned to pay for costs with a payroll tax, 6% each from employees and employers.

88. America's Town Meeting of the Air, "Should We Extend Social Security Now?" 8.

89. Poen, *Harry S. Truman Versus the Medical Lobby,* 33; and Huthmacher, *Senator Robert F. Wagner and the Rise of Urban Liberalism,* 293–94.

90. Steinmo and Watts, "It's the Institutions, Stupid!" 341.

91. Arthur J. Altmeyer, "Financing Hospital Care through Social Insurance: An Address before the Second War Conference of the American Hospital Association," September 15, 1943, 3, RG 47, Records of the Social Security Administration, 1946–1950, box 4-speeches by Arthur J. Altmeyer, NACP. This did not clarify whether 6% would cover the entire program or only the additional benefits.

92. Flynn, *Mess in Washington,* 40.

93. Kryder, *Divided Arsenal,* 246.

94. War Manpower Commission, "Memorandum: Text of address by Lawrence A. Appley, Deputy Chairman and Executive Director of the War Manpower Commission, on 'The War Manpower Outlook,' before the American management Association Conference on Industrial Relations," February 9, 1944, RG 211 Records of the War Manpower Commission, Record of Chairman, Correspondence with Government Officials, 1942–1945, box 1-Appley, NACP.

95. Flynn, *Mess in Washington,* 215.

96. "The End is in Sight," August 15, 1944. RG 211 Records of the War Manpower Commission, Record of Chairman, Correspondence with Government Officials, 1942–1945, box 1-Appley, NACP.

97. Lawrence A. Appley, "Memorandum to Paul V. McNutt," April 20, 1944, 3, RG 211, Records of the War Manpower Commission, Record of Chairman, Correspondence with Government Officials, 1942–1945, box 1-Appley, NACP.

98. Selective Service System, *Selective Service and Victory,* 3.

99. Selective Service System, *Selective Service and Victory,* 79.

100. Cohen and Barr, "War Mobilization and Reconversion Act of 1944," 10.

101. Flynn, *Mess in Washington,* 89.

102. Ibid., 232.

103. Social Security Administration, "Social Security History, The Third Round, 1943–1950."

104. Roosevelt, "Unless There is Security Here at Home," 41.

105. Ibid. Also see Franklin D. Roosevelt, "State of the Union Address," January 7, 1943, available at www.presidency.ucsb.edu/ws/index.php?pid=16386#axzz1GLaQ7pwo, accessed June 9, 2010.

106. Flynn, *Mess in Washington,* 232.

107. Donald G. Glascoff, "G.I. Joe's New Horizon," *American Legion Magazine* 37, no. 1 (August 1944): 15, 37. See also Edward N. Scheiberling, "A Look Ahead," *American Legion Magazine* 37, no. 5 (November 1944): 6; and U.S. Department of Veterans Affairs, "Born of Controversy: The GI Bill of Rights," available at www.gibill.va.gov/GI_Bill_Info/history.htm, accessed June 9, 2010.

108. U.S. Department of Commerce, Bureau of the Census, *Historical Statistics of the United States, Colonial Times to 1970,* 1144.

109. Arco Publishing Company, *GI Bill of Rights,* 13.

110. For the details of the veterans' pension, see President's Commission on Veterans' Pensions, *Veterans' Benefits in the United States,* 46; Ross, *Preparing for Ulysses,* 70; and Social Security Board, "The G.I. Bill of Rights," 3–6. The G.I. Bill of Rights was not the first major legislation during the war. The Servicemen's Allotment Act was established in 1942 to provide the dependents of the servicemen with cash assistance.

111. Cross, "VA Hospital and the Private Physician," 76.

112. U.S. Senate, 79th Congress, 1st session, Subcommittee on Wartime Health and Education, "Interim Report to Committee on Education and Labor: Wartime and Education, Health Needs of Veterans," Washington, D.C., 1945, 3.

113. Major Thomas M. Nial, "Men Not Disabled in Service Can Obtain Hospital Care," *New York Times,* May 30, 1945.

114. Pepper served as a senator from Florida from 1936 to 1951. After he lost the seat, he was elected to the House of Representatives in 1963 and served until his death in 1989.

115. Poen, *Harry S. Truman Versus the Medical Lobby,* 49–50; Quadagno, *One Nation Uninsured,* 26; U.S. Congress, Senate, Committee on Education and Labor, "Wartime Health and Education."

116. Poen, *Harry S. Truman Versus the Medical Lobby,* 50.

117. Ibid., 50.

118. "Health Insurance," *Washington Post,* May 19, 1944.

119. Poen, *Harry S. Truman Versus the Medical Lobby,* 45.

120. American Medical Association, "Evolution in Medicine," *Journal of the American Medical Association* 125, no. 13 (1944): 882.

121. American Medical Association, "Constructive Program for Medical Care," *Journal of the American Medical Association* 128, no. 12 (1945): 883.

122. Huthmacher, *Senator Robert F. Wagner and the Rise of Urban Liberalism,* 295.

123. "Disability and Medical Care Insurance: An Excerpt from the Board's Ninth Annual Report," *Social Security Bulletin* 8, no. 1 (1945): 12.

124. Huthmacher, *Senator Robert F. Wagner and the Rise of Urban Liberalism,* 295. On the expansion of the VA programs, see Mettler, *Soldiers to Citizens*.

125. Flynn, *Mess in Washington,* 240.

PART III: HEALTH INSURANCE IN THE POSTWAR PERIOD

1. The number of military casualties was about 300,000 in the United States and 1,300,000 in Japan. The number of civilian casualties was about 6,000 in the United States and 672,000 in Japan. *The New Encyclopaedia Britannica,* 15th ed.

CHAPTER 5: CONSOLIDATING THE HYBRID HEALTH INSURANCE SYSTEM

1. Anderson, *Health Services in the United States,* 119.

2. Clark, "Limits of State Autonomy," 268.

3. Eastwood, "Medical Services and the Veterans Administration," 1460; and Cross, "VA Hospital and the Private Physicians," 75.

4. U.S. Department of Commerce, Bureau of the Census, *Statistical Abstract 1952,* 212.

5. Ibid., 206.

6. Martin, "Federal Medicine," 1152.

7. American Medical Association, *Medical and Hospital Care of Veterans with Non-Service Connected Disabilities,* 15. See also Rumer, *American Legion,* 214–16.

8. American Medical Association, "A.M.A. Policy on Veterans' Medical Care, no. 4," *Journal of the American Medical Association* 155, no. 6 (1954): 601.

9. Major Thomas M. Nial, "Men Not Disabled in Service Can Obtain Hospital Care," *New York Times,* May 30, 1945.

10. "A National Health Program: Message from the President," *Social Security Bulletin* 8, no. 12 (1945): 11.

11. "Hospitals Kept Open for All Veterans," *New York Times,* February 1, 1946.

12. Starr, *Social Transformation of American Medicine,* 289.

13. Eastwood, "Medical Services and the Veterans Administration," 1461; and Starr, *Social Transformation of American Medicine,* 348. On April 18, 63 out of the 77 Class A medical schools coordinated their residency programs with the VA hospitals.

14. American Medical Association, "A.M.A. Policy on Veterans' Medical Care, no. 4," 602.

15. American Medical Association, "Medicine and the War: Medical Service for Veterans," *Journal of the American Medical Association* 130, no. 7 (February 1946): 416; and Portes, "V.A. Hospitals and Socialized Medicine," 268–69.

16. Sparrow, *From the Outside in,* 50–51; Gottschalk, *Shadow Welfare State*; and Klein, *For All These Rights*.

17. Derickson, "Health Insurance for All?" 1344.

18. Starr, *Social Transformation of American Medicine,* 313.

19. Becker, "Organized Labor," 124.

20. Sparrow, *From the Outside in,* 50.

21. Poen, *Harry S. Truman Versus the Medical Lobby,* 63.

22. Hacker, *Divided Welfare State,* 223.

23. Truman, "Special Message to the Congress Recommending a Comprehensive Health Program," 486–88.

24. Harry Truman, "Memorandum to Watson B. Miller," October 4, 1945, Elizabeth Pritchard Papers, MC 187, History of Medicine Division, National Library of Medicine, Bethesda, Maryland.

25. Quoted in Poen, *Harry S. Truman Versus the Medical Lobby,* 73.

26. Federal Security Agency, *Annual Report,* 425.

27. "Statement of Arthur J. Altmeyer, Chairman, Social Security Board on S. 1606, Before the Senate Committee on Education and Labor, April 4, 1946," 11, RG 47, Records of the Social Security Administration, Records of the Office of the Commissioner, Speeches and Articles, 1946–1950, 2-S.1606, NACP.

28. Poen, *Harry S. Truman Versus the Medical Lobby,* 98.

29. "Statement of Arthur J. Altmeyer, Chairman, Social Security Board on S. 1606, Before the Senate Committee on Education and Labor, April 4, 1946," 15–16, RG 47, Records of the Social Security Administration, Records of the Office of the Commissioner, Speeches and Articles, 1946–1950, 2-S.1606, NACP.

30. Truman, "Special Message to the Congress on Health and Disability Insurance," 490.

31. Fishbein, "Doctors at War," 10.

32. Ibid., 4.

33. Huthmacher, *Senator Robert F. Wagner and the Rise of Urban Liberalism,* 320.

34. Margaret McKiever, "Voluntary Prepayment Medical Care in Relation to a National Health Program," 9, included in Memorandum from Margaret McKiever to Margaret C. Klem, "Statements on Voluntary Health Insurance made at Hearings on S. 1606," May 31, 1946, Records of the Social Security Administration, Division of Research and Statistics, General Correspondence, 1946–1950, NACP.

35. Derickson, *Health Security for All,* 21.

36. Huthmacher, *Senator Robert F. Wagner and the Rise of Urban Liberalism,* 320.

37. American Medical Association, "The Wagner-Murray-Dingell Bill: Hearings on S. 1606—To Provide for a National Health Program," *Journal of the American Medical Association* 130, no. 15 (1946): 1022.

38. Ibid., 1023.

39. Department of Commerce, Bureau of the Census, *Historical Statistics of the United States, Colonial Times to 1970,* 1083.

40. Poen, *Harry S. Truman Versus the Medical Lobby,* 66.

41. Ibid., 74.

42. Ibid., 124.

43. Letter from Charles-Edward Amory Winslow to Isidore S. Falk, December 6, 1946, RG 47, Records of the Social Security Administration, Division of Research and Statistics, General Correspondence, 1946–1950, 3-011.1, NACP. Winslow had been an advocate for

universal health care since the 1920s. Falk was Winslow's former student. See Derickson, *Health Security for All,* 38–42.

44. Sparrow, *From the Outside in,* 50.

45. Poen, *Harry S. Truman Versus the Medical Lobby,* 94.

46. Derickson, *Health Security for All,* 111.

47. Derickson, "Health Insurance for All?" 1344.

48. Poen, *Harry S. Truman Versus the Medical Lobby,* 100.

49. Harry Truman, "Special Message to the Congress on Health and Disability Insurance, May 19, 1945," 250–51.

50. Poen, *Harry S. Truman Versus the Medical Lobby,* 114–15.

51. Anderson, *Health Services in the United States,* 133.

52. American Medical Association, "Washington Letter: Truman Indorses Ewing's 10 Year Health Program," *Journal of the American Medical Association* 138, no. 4 (1948): 300. The National Health Assembly was sponsored by the Federal Security Agency and was held in Washington, D.C., in May 1948.

53. Poen, *Harry S. Truman Versus the Medical Lobby,* 102.

54. U.S. House of Representatives, Committee on Expenditures in the Executive Departments, *Investigation of the Participation of Federal Officials,* 1–2.

55. Quoted in Sparrow, *From the Outside in,* 290.

56. Quadagno, *One Nation Uninsured,* 22.

57. U.S. House of Representatives, Committee on Expenditure in the Executive Departments, *Investigation of the Participation of Federal Officials,* 6.

58. Poen, *Harry S. Truman Versus the Medical Lobby,* 103.

59. U.S. House of Representatives, Committee on Expenditure in the Executive Departments, *Investigation of the Participation of Federal Officials,* 7.

60. American Medical Association, "Editorial: Propaganda Activities of Government Agencies," *Journal of the American Medical Association* 134, no. 15 (1947): 1246–47.

61. Campion, *AMA and U.S. Health Policy since 1940,* 160.

62. Poen, *Harry S. Truman Versus the Medical Lobby,* 108–9.

63. Ibid., 108–9.

64. Ibid., 106; and Gordon, "Why No National Health Insurance in the U.S.?" 282.

65. American Medical Association, "Compulsory Sickness Insurance," *Journal of the American Medical Association* 134, no. 6 (1947): 643.

66. Gordon, "Why No National Health Insurance in the U.S.?" 293.

67. Poen, *Harry S. Truman Versus the Medical Lobby,* 119.

68. Social Security Administration, "Social Security History, Chapter 3: The Third Round, 1943–1950," available at www.ssa.gov/history/corningchap3.html, accessed on July 1, 2010.

69. Lieberman, *Shifting the Color Line,* 34.

70. Starr, *Social Transformation of American Medicine,* 284.

71. U.S. Department of Commerce, *Statistical Abstract of the United States 1952,* 258.

72. Quoted in Campion, *AMA and U.S. Health Policy since 1940,* 154. This comment was made by Ernest B. Howard, who served as executive vice president of the AMA from 1968 to 1974.

73. Social Security Administration, "Social Security History." The endorsements came from no fewer than 1,829 organizations, including the Chamber of Commerce, the American Bar Association, the American Farm Bureau Federation, the American Dental Association, the American Legion, the General Federation of Women's Clubs, and others. The Catholic Church also reversed its long-term support for national health insurance.

74. Poen, *Harry S. Truman Versus the Medical Lobby,* 145.

75. Ibid., 152; and Starr, *Social Transformation of American Medicine,* 286. For details about Whitaker and Baxter, see Campion, *AMA and U.S. Health Policy since 1940,* 158–59.

76. Quoted in Starr, *Social Transformation of American Medicine,* 282.

77. Hacker, *Divided Welfare State,* 228.

78. Quoted in ibid., 228.

79. Poen, *Harry S. Truman Versus the Medical Lobby,* 180.

80. Ibid., 187; and Social Security Administration, "Social Security History."

81. Quoted in "The American Medical Association: Power, Purpose, and Politics in Organized Medicine Source," *Yale Law Journal* 63, no. 7 (May 1954): 955.

82. Ibid., 956.

83. Ibid., 956–57.

84. Anderson, *Health Services in the United States,* 126.

85. Kubie, "How Should the Medical Care of Veterans Be Organized?" 114.

86. Gordon, "Why No National Health Insurance in the U.S.?" 288.

87. "Too Much VA," *Chicago Daily Tribune*, September 15, 1953.

88. Perry Brown, "The Growing Attack on Veterans' Benefits," *American Legion Magazine,* vol. 47, no. 1 (July 1949): 14.

89. Ibid., 57.

90. Ibid., 60.

91. Ibid., 62–63.

92. Schrecker, *Age of McCarthyism,* 122.

93. James F. O'Neil, "How You Can Fight Communism," *American Legion Magazine* (August 1948): 44.

94. Poen, *Harry S. Truman Versus the Medical Lobby,* 90.

95. Ibid., 90–91.

96. Starr, *Social Transformation of American Medicine,* 283.

97. "V.A. Tightens Rule for Hospital Care: Acts to Curtail Free Treatment for Ex-G.I.'s Who Can Pay—Requests Prosecutions," *New York Times,* November 6, 1953.

98. American Medical Association, "A.M.A. Policy on Veterans' Medical Care, no. 1," *Journal of the American Medical Association* 154, no. 3 (1954): 264.

99. Poen, *Harry S. Truman Versus the Medical Lobby,* 163; and Campion, *AMA and U.S. Health Policy since 1940,* 166. The Senate voted down Truman's proposal, 60–32. Of the 22 Democrats who opposed Truman's plan, 20 were from southern states.

100. Anderson, *Health Services in the United States,* 135.

101. U.S. Department of Commerce, *Statistical Abstract 1955,* 226.

102. "A.M.A. Opposes Plan for Aid to G.I.'s Wives," *New York Times,* March 16, 1952; and "Medical Aid Urged for G.I. Families," *New York Times,* March 11, 1952.

103. Poen, *Harry S. Truman Versus the Medical Lobby,* 202.

104. Anderson, *Health Services in the United States,* 144.

105. Hacker, *Divided Welfare State,* 239.

CHAPTER 6: RESTORING THE PUBLIC HEALTH INSURANCE SYSTEM

1. Kawakami, *Gendai Nihon Iryōshi,* 494.

2. Kōseishō, *Isei Hyakunen,* 550–53.

3. Araki, "Kokumin Kenkōhoken Kumiai no Genjō to Sono Keiei Taisaku," 1.

4. See Dower, *Embracing Defeat.*

5. Within weeks after the Japanese surrender, the State-War-Navy Coordinating Committee (SWNCC), an interdepartmental body responsible for postwar planning, finalized its draft of "U.S. Initial Post-Surrender Policy for Japan" (SWNCC-150). Released in September 1945, SWNCC-150 established the broad objectives of the occupation, including the democratization and demilitarization of Japan and the relationship between U.S. forces and the Japanese government. The latter would remain intact but serve as an instrument for the implementation of occupation directives. A subsequent text, "Basic Directive for Post-Surrender Military Government in Japan Proper" (JCS-1380), issued by the Joint Chiefs of Staff in November 1945, set forth specific goals for the economic, political, and social reconstruction of postwar Japan. These reforms included a massive redistribution of farmland, the drafting of a new constitution, and the dismantling of Japan's industrial trusts (*zaibatsu*). See Dower, *Embracing Defeat,* 72; Takemae, *Inside GHQ,* 225–28.

6. Tatara, *1400 Years of Japanese Social Work,* 283.

7. Sugiyama, *Senryōki no Iryōkaikaku,* 44.

8. Quigley, "Democracy Occupies Japan," 522. Although MacArthur was supposed to consult with the Far Eastern Commission and the Allied Council for Japan, which were created as policymaking and advisory organizations by the Allied nations, most of his consultations resulted in a rubber stamp, or else he just ignored them. See Tatara, *1400 Years of Japanese Social Work,* 288, 372; and Sams, *DDT Kakumei,* 371.

9. Takemae, *Inside GHQ,* 225–27. The designations GHQ and SCAP are interchangeable in the Japanese context, although the title SCAP was given to MacArthur himself.

10. Cohen, *Remaking Japan.*

11. Supreme Commander for the Allies Powers (SCAP), Public Health and Welfare Section (PHW), "The Establishment of Public Health and Welfare Section," October 2, 1945, Record Group (RG) 331, Records of Allies Operational and Occupational Headquarters, World War II, 1907–1966, box 9382, file 8, NACP. The PHW continued until June 1951, when it was reduced to the Division of the Medical Section.

12. SCAP PHW, *Weekly Bulletin for 13–19 December 1948, Number 103* (Tokyo: Supreme Commander for Allied Powers, Public Health and Welfare Section, 1948), 1.

13. Sugiyama, *Senryōki no Iryōkaikaku,* 50.

14. Sodei, *Senryō Shitamono Saretamono,* 157.

15. Ibid., 130.

16. Tatara, *1400 Years of Japanese Social Work,* 336.

17. Milly, *Poverty, Equality, and Growth,* 101.

18. Sams, *DDT Kakumei,* 9, 250.

19. Nomura, *Nihon Ishikai,* 56.

20. Sugiyama, *Senryōki no Iryōkaikaku,* 44.

21. Tatara, *1400 Years of Japanese Social Work,* 410.

22. SCAP PHW, "Membership of Advisory Commission on Labor," December 30, 1945, RG 331, Records of Allies Operational and Occupational Headquarters, World War II, 1907–1966, box 9382, file 8, NACP; Takemae, "GHQ Rōdōka no Hito to Seisaku," 68–69. Stanchfield became director of Michigan's committee on unemployment policy after being requested by Walter P. Reuther, president of the United Automobile Workers.

23. Cohen, *Remaking Japan*; and Dower, *Embracing Defeat,* 220.

24. Milly, *Poverty, Equality, and Growth,* 103.

25. SCAP PHW, "Report on the Japanese Social Insurance Programs by the Labor Advisory Committee," 5, 1946, RG 331, Records of Allies Operational and Occupational Headquarters, World War II, 1907–1966, box Com 2-Japan, NACP.

26. SCAP PHW, "Report on the Japanese Social Insurance Programs by the Labor Advisory Committee," 5.

27. SCAP PHW, "Advisory Commission on Labor First Interim Report," 2, April 5, 1946, RG 331, Records of Allies Operational and Occupational Headquarters, World War II, 1907–1966, box 9382, file 8, NACP.

28. SCAP PHW, "Report on the Japanese Social Insurance Programs by the Labor Advisory Committee," 15.

29. Paul L. Stanchfield, "Memorandum to Colonel C.F. Sams: Suggested Organization and Personnel Requirement of 'Social Security and Insurance Division'," April 17, 1946, RG 331, Records of Allies Operational and Occupational Headquarters, World War II, 1907–1966, box 9382, file 8, NACP; SCAP PHW, "Request for Personnel," April 18–19, 1946, RG 331, Records of Allies Operational and Occupational Headquarters, World War II, 1907–1966, box 9382, file 8, NACP.

30. SCAP PHW, "Message," June 19, 1946, RG 331, Records of Allies Operational and Occupational Headquarters, World War II, 1907–1966, box 9382, file 8, NACP.

31. Lieberman, *Shifting the Color Line*.

32. SCAP PHW, "Memorandum for Record, 24 March 1947."

33. SCAP PHW, "Memorandum for Record: Candidates for Civilian Positions in Social Security and Insurance Division," January 21, 1947, RG 331, Records of Allies Operational and Occupational Headquarters, World War II, 1907–1966, box 9382, file 8, NACP.

34. SCAP PHW, "Outgoing Message (from SCAP to Washington)," March 24, 1947, RG 331, Records of Allies Operational and Occupational Headquarters, World War II, 1907–1966, box 9382, file 8, NACP; SCAP PHW, "Memorandum for Record." The Japanese government also showed its support by inviting the mission from the United States in order to advance the studies of social security policy. "Memorandum to Chief of Staff," August 22, 1947, RG 331, Records of Allies Operational and Occupational Headquarters, World War II, 1907–1966, box 9382, file 8, NACP.

35. Marmor, *Politics of Medicare,* 9.

36. Forest Harness, "Letter to the Honorable John Taber, United States House of Representatives," September 9, 1947, RG 331, Records of Allies Operational and Occupational Head-

quarters, World War II, 1907–1966, box 9383, file 8, NACP; Poen, *Harry S. Truman Versus the Medical Lobby,* 42–43.

37. SCAP PHW, "Memorandum for Record: Air Priority for Social Security Mission," August 14, 1947, RG 5, MacArthur Memorial Loose Papers, Public Health and Social Security Mission, Q-RA Rainbow Division, 1945–1951, Microfilm 64, MacArthur Memorial. Norfolk, Virginia.

38. Shakaihoshō, ed., *Nihon Shakai Hoshō Shiryō,* 10; Kōseishō Gojūnenshi Henshū Iinkai, *Kōseishō Gojūnenshi: Kijutsu Hen,* 816.

39. William Wandel, "Letter to I. S. Falk," June 14, 1947, RG 331, Records of Allies Operational and Occupational Headquarters, World War II, 1907–1966, box 9382, file 8, NACP.

40. Ibid.

41. Kōseishō Gojūnenshi Henshū Iinkai, *Kōseishō Gojūnenshi: Kijutsu Hen,* 810–11; and Sugiyama, *Senryōki no Iryōkaikaku,* 98.

42. Sugiyama, *Senryōki no Iryōkaikaku,* 100.

43. Kōseishō Gojūnenshi Henshū Iinkai, *Kōseishō Gojūnenshi: Kijutsu Hen,* 811: Yoshihara and Wada, *Nihon Iryōhoken Seidoshi,* 132. The Association-Managed Health Insurance within the Health Insurance Law was excluded from this proposal, although dependents of the AMHI beneficiaries were included.

44. Shakaihoshō, ed., *Nihon Shakaihoshō Shiryō,* 163–67.

45. Sugiyama, *Senryōki no Iryōkaikaku,* 98.

46. Saguchi, "Bebarijji Hōkokusho to Wagakuni Shakaihoshō Keikaku," 72, 74. Saguchi claims that GHQ's priority was cash assistance programs but not social insurance; therefore, Japanese scholars and officials tried to expand social security as "resistance to GHQ by academic consciousness." But this is not entirely true; as Saguchi himself notes, officials in PHW had a good relationship with the committee's members and influenced the content of its report. PHW officials initially wanted to integrate social insurance programs. It is more reasonable to speculate that because of their frequent communication with the Japanese experts, the PHW officials agreed to the creation of the comprehensive social security system in Japan at that time.

47. Hoken Kyoku, "Shakaihoshō Kenkyūkai ni tsuite," 32.

48. SCAP PHW, "Report on the Japanese Social Insurance Programs by the Labor Advisory Committee."

49. Suetaka, "Shakaihoshō Seido no Nihonteki Seikaku," 3. See also Saguchi, "Bebarijji Hōkokusho to Wagakuni Shakaihoshō Keikaku," 62.

50. Saguchi, "Bebarijji Hōkokusho to Wagakuni Shakaihoshō Keikaku," 71.

51. "Saitei Seikatsu wo Mamoru Shakaihoshō Seido" [Social security system to protect minimum life], *Asahi Shimbun,* October 12, 1946, quoted in Saguchi, "Bebarijji Hōkokusho to Wagakuni Shakaihoshō Keikaku: Nihon Shakaihokenshi no Issetsu," 665. See also Sugiyama, *Senryōki no Iryōkaikaku,* 100.

52. Soeda, *Seikatsuhogoseido no Shakaishi,* 87; and Milly, *Poverty, Equality, and Growth,* 103.

53. See Takemae, *Inside GHQ,* ch. 10.

54. Forest Harness, "Telegram to General Douglas MacArthur," August 20, 1947, RG 331, Records of Allies Operational and Occupational Headquarters, World War II, 1907–1966, box 9383, file 8, NACP.

55. War Department, "Radio Message to SCAP: Social Security Mission," August 30, 1947, RG 331, Records of Allies Operational and Occupational Headquarters, World War II, 1907–1966, box 2140, file 15, NACP.

56. War Department, "Radio Message to SCAP: Social Security Mission."

57. Poen, *Harry S. Truman Versus the Medical Lobby,* 110.

58. George F. Lull, "Letter to Crawford F. Sams," April 6, 1948, RG 331, Records of Allies Operational and Occupational Headquarters, World War II, 1907–1966, box 9382, file 7, NACP. Before his tenure as president, Lull was deputy surgeon general of the U.S. Army.

59. George W. Coon, "Letter to General Douglas MacArthur," September 30, 1947, RG 5, MacArthur Memorial Loose Papers, Public Health and Social Security Mission, Q-RA Rainbow Division, 1945–1951, Microfilm 64, MacArthur Memorial, Norfolk, Virginia.

60. William C. Black, "Letter to General Douglas MacArthur," September 20, 1947, RG 5, MacArthur Memorial Loose Papers, Public Health and Social Security Mission, Q-RA Rainbow Division, 1945–1951, Microfilm 64, MacArthur Memorial, Norfolk, Virginia. Although it is hard to gauge the extent of Shearon's influence on the AMA and its doctors, in a letter to Ray Smith, executive secretary of the Indiana State Medical Association, Shearon discusses arrangements to sell three hundred copies of the Harness release, adding, "There is great interest in this Mission to Japan story because it shows how high-handed the Social Security crowd is." Marjorie Shearon, "Letter to Ray E. Smith," October 3, 1947, box 1, Marjorie Shearon Papers, University of Oregon Libraries, Eugene, Oregon.

61. Douglas MacArthur, "Letter to Dr. Charles Farrell," September 7, 1947, RG 5, MacArthur Memorial Loose Papers, Public Health and Social Security Mission, Q-RA Rainbow Division, 1945–1951, Microfilm 64, MacArthur Memorial, Norfolk, Virginia.

62. Douglas MacArthur, "Letter to Forest Harness," August 22, 1947, RG 5, MacArthur Memorial Loose Papers, Public Health and Social Security Mission, Q-RA Rainbow Division, 1945–1951, Microfilm 64, MacArthur Memorial. Norfolk, Virginia.

63. "MacArthur Reports Socialized Medicine Is not Planned by U.S. for Japan," *Journal of the American Medical Association* 135, no. 2 (1947): 101.

64. Douglas MacArthur, "Letter to Forest Harness," December 24, 1947, RG 5, MacArthur Memorial Loose Papers, Public Health and Social Security Mission, Q-RA Rainbow Division, 1945–1951, Microfilm 64, MacArthur Memorial. Norfolk, Virginia.

65. Sugiyama, *Senryōki no Iryōkaikaku,* 101–4.

66. Barkev Sanders, "Dissent from Certain Portions of the Social Security Mission's Majority Report," November 1947, RG 331, Records of Allies Operational and Occupational Headquarters, World War II, 1907–1966, box 9383, file 3, NACP.

67. Barkev Sanders, "Dissent from Certain Portions of the Social Security Mission's Majority Report," 22.

68. SCAP PHW, "Social Security Mission Report," 1947, RG 331, Records of Allies Operational and Occupational Headquarters, World War II, 1907–1966, box 9382, file 10, NACP.

69. George F. Lull, "Letter to Crawford F. Sams."

70. Crawford F. Sams, "Speech to Washington University Medical Alumni Meeting, June 4, 1954," 1954, Crawford Sams Papers, box 3, Hoover Institution Library, Stanford University, Palo Alto, California. Sams also emphasized the differences between the political systems of Japan and the United States in a 1948 article. See Sams, "Japan's New Public Health Program," 9.

71. According to the editor of Sams's memoir, Zabelle Zakarian, Sams claimed to have been responsible for drafting Article 25. Sams, *Medic,* 272. Tatara also mentions that Brigadier General Whitney, chief of the Government Section, asked Sams to draft an article on social welfare, and Sams's idea was accepted. Tatara, *1400 Years of Japanese Social Work,* 328. According to Takemae, Beate Sirota of the Civil Rights Subcommittee of the SCAP constitutional steering committee also played a role. Takemae, *Inside GHQ,* 278–79.

72. Crawford F. Sams, "Speech to Washington University Medical Alumni Meeting," June 4, 1954, Crawford Sams Papers, box 3, Hoover Institution Library, Stanford University, Palo Alto, California.

73. Crawford F. Sams, "Letter to George Lull, 18 May 1948," May 18, 1948, RG 331, Records of Allies Operational and Occupational Headquarters, World War II, 1907–1966, box 9382, file 7, NACP.

74. SCAP PHW, "Social Security Mission Report."

75. "A.M.A. Officials Visit Japan," *Journal of the American Medical Association* 138, no. 1 (1948): 79.

76. American Medical Association, "Report of the Mission of the American Medical Association," 1948, RG 331, Records of Allies Operational and Occupational Headquarters, World War II, 1907–1966, box 9383, file 1, NACP.

77. Tatara, *1400 Years of Japanese Social Work,* 349.

78. Owen J. Toland, "Letter to General Douglas MacArthur, 26 September 1947," September 26, 1947, RG 5, MacArthur Memorial Loose Papers, Public Health and Social Security Mission, Q-RA Rainbow Division, 1945–1951, Microfilm 64, MacArthur Memorial, Norfolk, Virginia.

79. Kawakami, *Gendai Nihon Iryōshi,* 501; Saguchi, *Kokumin Kenkōhoken,* 77–79; and Yoshihara and Wada, *Nihon Iryōhoken Seidoshi,* 81.

80. Kojima Yonekichi, "Kokumin Kenkōhoken Hō no Kaisei ni taisuru Hihan" [Criticism of the 1948 Amendment of the National Health Insurance], *Shakaihoken Jōhō* 2, no. 10 (1948): 4.

81. Saguchi, *Kokumin Kenkōhoken,* 79.

82. Kōseishō Gojūnenshi Henshū Iinkai, *Kōseishō Gojūnenshi: Kijutsu Hen,* 822–24.

83. Ibid., 816.

84. Ibid., 498.

85. Kawakami, *Gendai Nihon Iryōshi,* 498; Sugiyama, *Senryōki no Iryōkaikaku,* 197; and Dower, *Embracing Defeat,* 540–41.

86. Kōseishō Gojūnenshi Henshū Iinkai, *Kōseishō Gojūnenshi: Kijutsu Hen,* 810–14, 826–28.

87. Ibid., 831–32; Saguchi, *Kokumin Kenkōhoken,* 86; and Yoshihara and Wada, *Nihon Iryōhoken Seidoshi,* 129.

88. Nakata, "Shakai Hoshō Seido Shingikai Secchi ni tsuite," 7.

89. Suetaka, "Shakaihoshō Seido no Nihonteki Seikaku," 2.

90. Kōseishō Gojūnenshi Henshū Iinkai, *Kōseishō Gojūnenshi: Kijutsu Hen,* 837; and Sugita, "Universal Health Insurance," 164.

91. Quoted in Sugita, "Universal Health Insurance," 163.

92. Even in the late period of the occupation, PHW's power was still strong, and Sams got involved in key issues of health care. Sams sought to abolish the Japanese way of medicine by prohibiting doctors from selling drugs. Sams confronted the JMA, which claimed that doctors could not survive without sales of drugs because the national fee schedule was low. In response to Sams's stubborn opposition, Tamiya Takeo and Takemi Taro, the JMA's president and vice president, respectively, resigned. Takemi Tarō later became the president of the JMA from 1957 to 1982. Miwa, *Mōi Takemi Tarō,* 76.

93. Health insurance had been considered for the poor, but the idea gradually disappeared in the 1940s. In 1950, more than 50% of all patients started to use health insurance. Sugita, "Universal Health Insurance," 163.

94. See Campbell and Naoki, *Art of Balance in Health Policy.*

Bibliography

PRIMARY SOURCES

U.S. National Archives, College Park, Maryland

Records of Allies Operational and Occupational Headquarters, World War II, 1907–1966
Records of the Social Security Administration
Records of the Social Security Board
Records of the War Manpower Commission

Newspapers

Asahi Shimbun
Chicago Daily Tribune
The New York Times
Tokyo Asahi Shimbun
The Washington Post
Yomiuri Shimbun

Miscellaneous

Crawford Sams Papers. Hoover Institution Library. Stanford University, Palo Alto, California.
Elizabeth Prichard Papers. National Library of Medicine, Bethesda, Maryland.
MacArthur Memorial Loose Papers. Macarthur Memorial, Norfolk, Virginia.
Marjorie Shearon Papers. University of Oregon Libraries, Eugene, Oregon.
The New Encyclopaedia Britannica. 15th edition. (Chicago: Encyclopaedia Britannica, 1992).
Shūgiin giji sokkiroku, vols. 70–72. Tokyo: Tokyo University Press, 1984–85.

SECONDARY SOURCES

Addison, Paul. *The Road to 1945: British Politics and the Second World War.* London: Jonathan Cape, 1975.

Adler, Stuart W. "Medical Care for Dependents of Men in Military Service." *American Journal of Public Health and the Nation's Health* 33, no. 6 (1943): 645–50.

Altmeyer, Arthur J. "War and Post-War Problems." In *War and Post-War Social Security,* ed. Wilbur J. Cohen. Washington, DC: American Council on Public Affairs, 1942.

Amenta, Edwin. "What We Know about the Development of Social Policy: Comparative and Historical Research in Comparative and Historical Perspective." In *Comparative Historical Analysis in the Social Science,* ed. James Mahoney and Dietrich Rueschemeyer. New York: Cambridge University Press, 2003.

American Medical Association. *Caring for the Country: A History and Celebration of the First 150 Years of the American Medical Association.* Chicago: American Medical Association, 1997.

———. *Medical and Hospital Care of Veterans with Non-Service Connected Disabilities: A Review of American Medical Association Policy.* Chicago: American Medical Association, 1953.

America's Town Meeting of the Air. "Should We Extend Social Security Now?" *Bulletin of America's Town Meeting of the Air* 8, no. 40 (1943): 3–11.

Anderson, Odin W. *Health Services in the United States: A Growth Enterprise since 1875*. Ann Arbor, MI: Health Administration Press, 1985.

Araki Kazunari. "Kokumin Kenkōhoken Kumiai no Genjō to sono Keiei Taisaku" [Conditions of the national health insurance associations and proposed reforms]. *Shakaihoken Jihō* 20, nos. 7-8 (1945): 1–3.

Arco Publishing Company. *GI Bill of Rights for Service Men and Women, Wives, Mothers, Families*. New York: Arco Publishing Company, 1944.

Baker, Helen, and Dorothy Dahl. *Group Health Insurance and Sickness Benefits Plans in Collective Bargaining.* Princeton, NJ: Industrial Relations Section, Dept. of Economic and Social Institutions, Princeton University, 1945.

Becker, Harry. "Organized Labor and the Problem of Medical Care." *Annals of the American Academy of Political and Social Science* 273 (January 1951): 122–30.

Bensel, Richard. *Yankee Leviathan: The Origins of Central State Authority in America, 1859–1877*. New York: Cambridge University Press, 1990.

Berkowitz, Edward D. *Mr. Social Security: The Life of Wilbur J. Cohen*. Lawrence: University Press of Kansas, 1995.

Berman, Sheri. "Path Dependency and Political Action: Reexamining Responses to the Depression." *Comparative Politics* 30, no. 4 (1998): 379–400.

Bloomfield, J. J. "Influence of War on Industrial Medicine." *War Medicine* 2, no. 4 (1942): 561–70.

Brinkley, Alan. *The End of Reform: New Deal Liberalism in Recession and War.* New York: Alfred A. Knopf, 1995.

Bruce, William R. "Government Provides Maternity Aid for Service Men's Wives: Obstetrics Program Leaves Choice of Physician up to Each Individual." *Medical Economics* 20, no. 12 (1943): 133–41.

Campbell, John C., and Naoki Ikegami. *The Art of Balance in Health Policy: Maintaining Japan's Low-Cost, Egalitarian System*. New York: Cambridge University Press, 1998.

Campion, Frank D. *The AMA and U.S. Health Policy since 1940*. Chicago: Chicago Review Press, 1984.

Clark, Thomas R. "The Limits of State Autonomy: The Medical Cooperatives of the Farm Security Administration, 1035–1946." *Journal of Policy History* 11, no. 3 (1999): 257–82.

Cohen, Theodore. *Remaking Japan: The American Occupation as New Deal*. London: Collier Macmillan, 1987.

Cohen, Wilbur J. "Next Steps and Future Goals." In *War and Post-War Social Security,* ed. Wilbur J. Cohen. Washington, DC: American Council on Public Affairs, 1942.

Cohen, Wilbur J., and Jessica H. Barr. "War Mobilization and Reconversion Act of 1944: An Analysis of the 'George Bill.'" *Social Security Bulletin* 7, no. 10 (1944): 10–15.

Collier, Ruth B., and David Collier. *Shaping the Political Arena: Critical Junctures, the Labor Movement, and Regime Dynamics in Latin America*. Princeton, NJ: Princeton University Press, 1991.

Cross, Ronald R. "The VA Hospital and the Private Physician." *Illinois Medical Journal* 103 (February 1953): 75–77.

David, Paul A. "Clio and the Economics of QWERTY." *American Economic Review* 75 (1985): 332–37.

Derickson, Alan. *Health Security for All: Dreams of Universal Health Care in America*. Baltimore: Johns Hopkins University Press, 2005.

———. "Health Insurance for All? Social Unionism and Universal Health Insurance, 1935–1958." *Journal of American History* 80, no. 12 (1994): 1333–56.

Dobbin, Frank R. "The Origins of Private Social Insurance: Public Policy and Fringe Benefits in America, 1920–1950." *Journal of Sociology* 97, no. 5 (1992): 1416–50.

Dower, John W. *Embracing Defeat: Japan in the Wake of World War II*. New York: W.W. Norton / New Press, 1999.

Dryzek, John, and Robert E. Goodin. "Risk-Sharing and Social Justice: The Motivational Foundation of the Post-War Welfare State." *British Journal of Political Science* 16, no. 1 (1986): 1–34.

Dudziak, Mary L. *Cold War Civil Rights: Race and the Image of American Democracy*. Princeton, NJ: Princeton University Press, 2002.

Eastwood, Edmund. "Medical Services and the Veterans Administration." *New York Journal of Medicine* 46 (July 1946): 1459–62.

Eckstein, Harry. *The English Health Service: Its Origins, Structure, and Achievements*. Cambridge, MA: Harvard University Press, 1958.

Egi Tsubasa and Naoyasu Kataoka. "Shippeihoken Hōan ni tsuiteno Setsumei" [Explanation of sickness insurance plan]. In *Nihon Shakaihoshō Shiryō I* [Documents on Japanese social security, Part 1], ed. Shakaihoshō Kenkyūjo [Social security research institute]. Tokyo: Shiseido Shakaihoshō Kenkyūjo, 1981.

Eisner, Marc Allen. *From Warfare State to Welfare State: World War I, Compensatory State Building, and the Limits of the Modern Order*. University Park: Pennsylvania State University Press, 2000.

Eliot, Martha M. "Maternity Care for Service Men's Wives." *Survey Midmonthly* 79, no. 4 (1943): 113–14.

Falk, Isidore S. "Mobilizing for Health Security." In *War and Post-War Social Security,* ed. Wilbur J. Cohen. Washington, DC: American Council on Public Affairs, 1942.

Federal Security Agency. *Annual Report of the Federal Security Agency for the Fiscal Year of 1946*. Washington, DC: U.S. Government Printing Office, 1946.

Fishbein, Morris. "Doctors at War." In *Doctors at War,* ed. Morris Fishbein. New York : E.P. Dutton, 1945.

———. *A History of the American Medical Association, 1847–1947*. Philadelphia: Saunders, 1947.

Flynn, George Q. *The Mess in Washington: Manpower Mobilization in World War II*. Westport, CT: Greenwood Press, 1979.

Fuse Shōichi. *Ishi no Rekishi: Sono Nihonteki Tokuchō*. [History of doctors: What makes it Japanese?]. Tokyo: Chūō Kōronsha, 1979.

Garon, Sheldon. *Molding Japanese Minds: The State in Everyday Life*. Princeton, NJ: Princeton University Press, 1997.

George, Henry. *Progress and Poverty: An Inquiry into the Cause of Industrial Depressions and of Increase of Want with Increase of Wealth*. 1879; repr. New York: Page & Co., 1912.

Glascoff, Donald G. "G.I. Joe's New Horizon," *American Legion Magazine* 37, no. 1 (August 1944):15, 37.

Gluck, Carol. *Japan's Modern Myths: Ideology in the Late Meiji Period*. Princeton, NJ: Princeton University Press, 1985.

Gordon, Colin. "Why No National Health Insurance in the U.S.? The Limits of Social Provision in War and Peace, 1941–1948." *Journal of Policy History* 9, no. 3 (1997): 277–310.

Gottschalk, Marie. *The Shadow Welfare State: Labor, Business, and the Politics of Health Care in the United States*. Ithaca, NY: Cornell University Press, 2000.

Great Britain, Central Statistical Office. *Statistical Abstract for the United Kingdom, vol. 82*. London: His Majesty's Stationery Office, 1939.

Hacker, Jacob S. *The Divided Welfare State: The Battle over Public and Private Social Benefits in the United States*. New York: Cambridge University Press, 2002.

———. "The Historical Logic of National Health Insurance: Structure and Sequence in the Development of British, Canadian, and U.S. Medical Policy." *Studies in American Political Development* 12 (Spring 1998): 57–130.

Hall, John W. "A Monarch for Modern Japan." In *Political Development in Modern Japan,* ed. Robert E. Ward. Princeton: Princeton University Press, 1968.

Hartz, Louis. *The Liberal Tradition in America: An Interpretation of American Political Thought since the Revolution*. 1955; repr. San Diego: Harcourt Brace Jovanovich, 1991.

Hines, Frank T. "Medical Care Program of the Veterans Administration." *Annals of the American Academy of Political and Social Science* 239 (May 1945): 73–79.

———. "Progress of the Part the Veterans' Administration Is Playing in the National Defense Program." *The Military Surgeon* 90 (February 1942): 113–19.

———. "The Veterans' Administration and National Defense." *The Military Surgeon* 88 (January 1941): 24–28.

Hirai Akira. "Nento no Ji" [New Year's greeting]. *Kenkōhoken Jihō* 17–18, no. 1 (1942): 2–3.

Hirshfield, Daniel S. *The Lost Reform: The Campaign for Compulsory Health Insurance in the United States*. Cambridge, MA: Harvard University Press, 1970.

Hoken Kyoku [Bureau of Insurance] Shomu Ka [General Affairs Division]. "Shakaihoshō Kenkyūkai ni tsuite" [Workshop on the social security system]. *Shakaihoken Jihō* 21, nos. 6-7 (1946): 32–33.

Hollingsworth, J. Rogers. *Political Economy of Medicine: Great Britain and the United States*. Baltimore: Johns Hopkins University Press, 1986.

Huthmacher, J. Joseph. *Senator Robert F. Wagner and the Rise of Urban Liberalism*. New York: Atheneum, 1968.

Ikuta Makoto, *Nihon Rikugunshi* [The history of the Japanese army]. Tokyo: Kyōikusha, 1980.

Immergut, Ellen. *Health Politics: Interests and Institutions in Western Europe*. New York: Cambridge University Press, 1992.

Jacobson, Gary C. *The Politics of Congressional Elections*. 7th edition. New York: Pearson/Longman, 2009.

Janowitz, Morris. *Social Control of the Welfare State*. New York: Elsevier, 1976.

Jefferys, Kevin. *War and Reform: British Politics during the Second World War*. New York: Manchester University Press, 1994.

Jensen, Laura. *Patriots, Settlers, and the Origin of American Social Policy*. New York: Cambridge University Press, 2003.

Johnson, Chalmers. *MITI and the Japanese Miracle: The Growth of Industrial Policy, 1925–1975*. Stanford: Stanford University Press, 1982.

Kasahara Hidehiko. *Nihon no Iryōgyōsei: Sono Rekishi to Kadai* [Japanese health care administration: Its History and Problems]. Tokyo: Keio University Press, 1999.

Kasza, Gregory J. *The Conscription Society: Administered Mass Organizations*. Yale University Press, New Haven, 1995.

———. *One World of Welfare: Japan in Comparative Perspective*. Ithaca, NY: Cornell University Press, 2006.

———. "War and Comparative Politics." *Comparative Politics* 28, no. 3 (1996): 355–73.

———. "War and Welfare Policy in Japan." *Journal of Asian Studies* 61, no. 2 (2002): 417–35.

Katō Yoko. *Chōheisei to Kindai Nihon* [The conscription system and modern Japan]. Tokyo: Yoshikawa Kōbunsha, 1996.

Katznelson, Ira. *City Trench: Urban Politics and the Patterning of Class in the United States*. Chicago: University of Chicago Press, 1981.

Katznelson, Ira, and Martin Shefter, eds. *Shaped by War and Trade: International Influences on American Political Development*. Princeton, NJ: Princeton University Press, 2002.

Kaufman, Martin. *American Medical Education: The Formative Years, 1765–1910*. Westport, CT: Greenwood Press, 1941.

Kawakami Takeshi. *Gendai Nihon Iryōshi* [History of modern Japanese health]. Tokyo: Keisō shobō, 1965.

Kessler-Harris, Alice. *In Pursuit of Equity: Women, Men, and the Quest for Economic Citizenship in Twentieth-Century America*. New York: Oxford University Press, 2001.

Kido Kōichi. "Shukuji" [A congratulatory address]. *Nihon Sangyo Eisei Kyōkai Kaihō* 90 (December 1938): 15–16.

Kitahara Ryūji. *Kenkōhoken to Ishikai: Shakaihoken Sōshiki ni okeru Ishi to Iryō* [The health insurance system and the doctor's association in Japan: Doctors and medicine at the beginning of the social health insurance]. Tokyo: Tōshindō, 1999.

Kitajima Taichi. *Kitajima Taichi Jiden* [Autobiography of Taichi Kitajima]. Tokyo: Kitajima Sensei Kinen Jigyōkai, 1955.

Klausen, Jytte. *War and Welfare: Europe and the United States, 1945 to the Present*. New York: Palgrave, 1998.

Klein, Jennifer. *For All These Rights: Business, Labor, and the Shaping of America's Public-Private Welfare State*. Princeton, NJ: Princeton University Press, 2003.

Klein, Rudolf. *The Politics of the National Health Service*. 2nd edition. 1983; repr. New York: Longman, 1989.

Klem, Margaret C. "Some Recent Developments in Voluntary Health Insurance." *Social Security Bulletin* 5, no. 8 (1942): 5–16.

Koizumi Chikahiko. "Hoken Kokusaku no Konpon Mondai" [Fundamental problem of insurance policy]. *Nihon Sangyō Eisei Kyōkai Kaihō* 90 (December 1938): 1–7.

———. *Kokumin Tairyoku no Genjō wo Nobe Kokumin no Funki wo Nozomu* [Current condition of people's strength and my hope in people's action]. Tokyo: Kokumin seishin sōdōin chūō dōmei, 1938.

Kōseishō Gojūnenshi Henshū Iinkai [Fifty-year history of the Ministry of Health and Welfare editorial committee]. *Kōseishō Gojūnenshi: Kijutsuhen* [Fifty-year history of the Ministry of Health and Welfare: Documentary volume]. Tokyo: Chūō Hōki Shuppan, 1988.

———. *Kōseishō Gojūnenshi: Shiryōhen* [Fifty-year history of the Ministry of Welfare: Statistics volume]. Tokyo: Chūō Hōki Shuppan, 1988.

Kōseishō Hoken Kyoku Kokumin Kenkōhoken Ka [The National Health Insurance Division, Social Affairs Bureau, the Ministry of Health and Welfare] and Kokumin Kenkōhoken Chūō Kai [All-Japan Federation of National Health Insurance Organizations]. *Kokumin Kenkōhoken Yonjūnenshi* [A forty-year history of National Health Insurance]. Tokyo: Gyōsei, 1979.

Kōseishō Imu Kyoku [Ministry of Health and Welfare, Medical Affairs Bureau]. *Isei Hyakunen* [One-hundred-year history of medicine]. Tokyo: Gyōsei, 1976.

Kōseishō Nijūnenshi Henshū Iinkai [Twenty-year history of the Ministry of Health and Welfare editorial committee]. *Koseishō Nijūnenshi* [Twenty-year history of the Ministry of Health and Welfare]. Tokyo: Kosei Mondai Kenkyukai, 1960.

Kruif, Paul De. *Kaiser Wakes the Doctors*. New York: Harcourt Brace and Company, 1943.

Kryder, Daniel. *Divided Arsenal: Race and the American State during World War II*. New York: Cambridge University Press, 2000.

Kubie, Lawrence S. "How Should the Medical Care of Veterans Be Organized?" *Military Affairs* 9, no. 2 (Summer 1945):114–19.

Kubo Fumiaki. *Nyūdīru to Amerika Minshusei: Nōgyōseisaku wo meguru Seijikatei* [American democracy and the New Deal: Political process of agricultural policy]. Tokyo: Tokyo University Press, 1988.

Kurosawa Fumitaka. *Taisenkanki no Nihon Rikugun* [The Japanese army between World War I and World War II]. Tokyo: Misuzu Shobō, 2000.

Lesparre, Michael. "A Century of the AHA." *Hospitals and Health Networks* (January 1998): 38–49.

Lieberman, Robert C. *Shifting the Color Line: Race and the American Welfare State*. Cambridge, MA: Harvard University Press, 1998.

Light, Jennifer S. *From Warfare to Welfare: Defense Intellectuals and Urban Problems in Cold War America*. Baltimore: Johns Hopkins University Press, 2003.

Lindenmeyer, Kriste. *A Right to Childhood: The U.S. Children's Bureau and Child Welfare, 1912–46*. Urbana: University of Illinois Press, 1997.

Lipset, Seymour Martin. *American Exceptionalism: A Double-Edged Sword*. New York: W.W. Norton, 1996.

Magnuson, Paul B. "Medical Care for Veterans." *Annals of the American Academy of Political and Social Science* 273 (January 1951): 76–83.

Marmor, Theodore. *The Politics of Medicine*. New York: A. de Gruyten, 2000.

Martin, Walter C. "Federal Medicine: Its Impact on the Medical Care of the American People." *Southern Medical Journal* 46 (December 1953): 1151–55.

Mayhew, David R. "War and American Politics," *Perspectives on Politics* 3, no. 3 (2005): 473–93.

Mettler, Suzanne. *Soldiers to Citizens: The G.I. Bill and the Making of the Greatest Generation*. New York: Oxford University Press, 2005.

Milly, Deborah J. *Poverty, Equality, and Growth: The Politics of Economic Need in Postwar Japan*. Cambridge, MA: Harvard University Asia Center, 1999.

Miura Toyohiko. *Rōdō to Kenkō no Rekishi* [A history of workers and their health]. Kawasaki, Kanagawa: Rōdō Kagaku Kenkyūjo Shuppanbu, 1988.

Miwa Kazuo. *Mōi Takemi Tarō* [Fighting doctor, Takemi Tarō]. Tokyo: Tokuma Shoten, 1995.

Mizuno Hajime. *Dare mo Kakanakatta Nihon Ishikai* [The untold story of the Japan Medical Association]. Tokyo: Sōshisha, 2003.

Morone, James A. *The Democratic Wish: Popular Participation and the Limits of American Government*. New York: Basic Books, 1990.

Mulligan, Joan Elizabeth. *Three Federal Interventions on Behalf of Childbearing Women: The Sheppard-Towner Act, Emergency Maternity and Infant Care, and the Maternal and Child Health and mental Retardation Planning Amendments of 1963*. Ph.D. dissertation, University of Michigan, 1976.

Muramatsu, Michio and Ellis S. Krauss. "Bureaucrats and Politicians in Policymaking: The Case of Japan." *American Political Science Review* 78, no. 1 (March 1984): 126–46.

Myrdal, Gunner. *An American Dilemma: The Negro Problem and Modern Democracy*. New York: Harper and Row, 1982.

Naikaku Kanbō [Cabinet Secretariat], ed. *Naikaku Seido 70 nenshi* [Seventy-year history of the Cabinet]. Tokyo: Ōkura Insatsukyoku, 1955.

Nakata Yoshio. "Shakai Hoshō Seido Shingikai Secchi ni tsuite" [Thinking about the establishment of the Advisory Council on the Social Security System]. *Shakaihoken Jōhō* 3, no. 1 (1949): 27–28.

Nelson, Daniel M. "Social Security Administration." In *Government Agencies,* ed. Donald R. Whitnah. Westport, CT: Greenwood Press, 1983.

"News, Notes, and Discussion: Acceleration of Hospital Construction." *Medical Bulletin of the Veterans Administration* 19 (January 1943): 359–60.

Nicklason, Fred. "Henry George: Social Gospeller." *American Quarterly* 22, no. 3 (Autumn 1970): 654.

Nihon Isikai Soritsu Gojusshunen Kinen jigyo Suishin Iinkai, *Nihon Ishikai Soritsu Kinenshi: Sengo Gojunen no Ayumi* [Commemoration of the founding of the Japan Medical Association: Fifty years after World War II] (Tokyo: Japan Medical Association, 1997).

Nihon Kindai Shiryō Kenkyūkai [Society for Japanese Modern Historical Materials], ed. *Nihon Rikukaigun no Seido, Soshiki, Jinji* [Institution, organization, and personal affairs of the Japanese army and navy]. Tokyo: Tokyo University Press, 1971.

Niki Ryu. *Iryōkeizai/Seisakugaku no Shiten to Kenkyu Hōhō* [Research methods in medical economics and policy]. Tokyo: Keisō Shobō, 2006.

Nitobe Inazō. *Bushido: The Soul of Japan*. 1905; repr. Tokyo: Kodansha International, 2002.

Noguchi Yukio. *1940 Nen Taisei: Saraba Senji Keizai* [The 1940 system: Japan under the wartime economy]. Tokyo: Toyo Keizaishinpōsha, 1995.

Nomura Taku. *Iryō to Kokumin Seikatsu: Shōwa Iryōshi* [Medicine and people's lives]. Tokyo: Aoki Shoten, 1981.

———. *Nihon Ishikai* [The Japan Medical Association]. Tokyo: Keiso Shobō, 1976.

Numbers, Ronald L. *Almost Persuaded: American Physicians and Compulsory Health Insurance, 1912–1920*. Baltimore: Johns Hopkins University Press, 1978.

Ōe Shinobu. *Chōheisei* [The conscription system]. Tokyo: Iwanami Shinsho, 1981.

Okada Fumihide. *Dotō no Naka no Koshū* [A small boat in rough waves]. Tokyo: Okada Fumihide Jijoden Kankōkai, 1974.

Parsons, Talcott. "Social Change and Medical Organization in the United States: A Sociological Perspective." *Annals of the American Academy of Political and Social Science* 346 (March 1963): 21–33.

Pempel, T. J., and Keiichi Tsunekawa. "Corporatism without Labor? The Japanese Anomaly." In *Trends toward Corporatist Intermediation,* ed. Philippe C. Schmitter and Gerhard Lehmbruch. Beverly Hills, CA: Sage Publications, 1979.

Perrott, John, and Burnet M. Davis. "The War and the Distribution of Physicians." *Public Health Reports* 58, no. 42 (1943): 1545–54.

Pierson, Paul. "Not Just What but When: Timing and Sequence in Political Process." *Studies in American Political Development* 14 (Spring 2000): 72–92.

Poen, Monte M. *Harry S. Truman Versus the Medical Lobby: The Genesis of Medicare*. Columbia: University of Missouri Press, 1979.

Portes, Caesar. "V.A. Hospitals and Socialized Medicine." *Illinois Medical Journal* 103 (May 1953): 268–69.

President's Commission on Veterans' Pensions. *Veterans' Benefits in the United States: Findings and Recommendations*. Washington, DC: U.S. Government Printing Office, 1956.

Pyle, Kenneth B. *The Making of Modern Japan*. 2nd edition. Lexington, MA.: D.C. Heath and Company, 1996.

Quadagno, Jill. *One Nation Uninsured: Why the U.S. Has No National Health Insurance*. New York: Oxford University Press, 2005.

Quigley, Harold S. "Democracy Occupies Japan." *Virginia Quarterly Review* 23 (Spring 1947): 520–31.

Rinehart, Sue T. "Maternal Health Care Policy: Britain and the United States." *Comparative Politics* 19, no. 2 (1987): 193–211.

Roosevelt, Franklin D. "Address at the Dedication of the National Institute of Health, Bethesda, Maryland." October 31, 1940. In *The Public Papers of the Presidents of the United States, Franklin D. Roosevelt: Complied With Special Material and Explanatory Notes by Samuel I. Rosenman, 1940 Volume*. New York: Harper and Brothers, 1950, pp. 525–29.

———. "December 7, 1941—A Date Which Will Live in Infamy: Address to Congress Asking that a State of War be Declared between the United States and Japan." December 8, 1941. In *The Public Papers of the Presidents of the United States, Franklin D. Roosevelt: Complied With Special Material and Explanatory Notes by Samuel I. Rosenman, 1941 Volume*. New York: Harper and Brothers, 1950, pp. 514–16.

———. "Unless There Is Security Here at Home, There Cannot Be Lasting Peace in the World: Message to the Congress on the State of the Union." January 11, 1944, in *The Public Papers of the Presidents of the United States, Franklin D. Roosevelt: Complied With Special Material and Explanatory Notes by Samuel I. Rosenman, 1944–45 Volume*. New York: Harper and Brothers, 1950, pp. 32–44.

Ross, Davis R. B. *Preparing for Ulysses: Politics and Veterans during World War II*. New York: Columbia University Press, 1969.

Rowntree, Leonard G. "Fit to Fight: The Medical Side of Selective Service." In *Doctors at War,* ed. Morris Fishbein. New York: E.P. Dutton, 1945.

Rumer, Thomas A. *The American Legion: An Official History, 1919–1989*. New York: M. Evans, 1990.

Saguchi Takashi. "Bebarijji Hōkokusho to Wagakuni Shakaihoshō Keikaku: Nihon Shakaihokenshi no Issetsu" [Plan on Japanese social security and Beveridge Report: A history of Japanese social insurance]. *Waseda Shōgaku* 143 (January 1960): 61–76.

———. "Kokumin Kenkōhoken to Iryō no Shakaika" [The National Health Insurance Law and socialization of medicine]. *Toshi Mondai* 49, no. 11 (1958): 2–10.

———. *Kokumin Kenkōhoken: Keisei to Tenkai* [The National Health Insurance Law: The formation and development]. Tokyo: Kōseikan, 1995.

Sakaguchi Masayuki. *Nihon Kenkōhokenhō Seiritsushiron* [History of National Health Insurance Laws in Japan]. Kyoto: Kōyō Shobō, 1985.

Sakai Shizu. *Nihon no Iryōshi* [History of Japanese medicine]. Tokyo: Tokyo Shoseki, 1982.

Sams, Crawford F. *DDT Kakumei: Senryōki no Iryō Fukushi Seisaku wo Kaisō suru* [DDT revolution: Thinking back on health welfare policy during the occupation]. Tokyo: Iwanami Shoten, 1986.

———. "Japan's New Public Health Program." *Military Government Journal* 1 (September–October 1948): 9–10, 14.

———. *Medic: The Mission of an American Military Doctor in Occupied Japan and Wartime Korea*. Zabelle Zakarian, ed. Armonk, NY: Sharpe, 1998.

Scheiberling, Edward N. "A Look Ahead," *American Legion Magazine* 37, no. 5 (November 1944):6.

Schrecker, Ellen. *The Age of McCarthyism: A Brief History with Documents*. 2nd edition. Boston: Bedford/St. Martin's, 2002.

Selective Service System. *Selective Service and Victory: The 4th Report of the Director of Selective Service 1944–1945, with a Supplement for 1946–1947*. Washington, DC: U.S. Government Printing Office, 1948.

———. *Selective Service as the Tide of War Turns: The 3rd Report of the Director of Selective Service, 1943–1944*. Washington, DC: U.S. Government Printing Office, 1945.

———. *Selective Service at Work in Peacetime*. Washington, DC: U.S. Government Printing Office, 1942.

———. *Selective Service in Wartime: Second Report of the Director of Selective Service*. Washington, DC: U.S. Government Printing Office, 1943.

Shakaihoshō Kenkyūjo [Social Security Research Institute], ed. *Nihon Shakaihoshō Zenshi Shiryō: Shakaioken* [Prehistory of Japanese social security: Social insurance]. Tokyo: Shiseidō, 1981.

———. *Nihon Shakaihoshō Shiryō, I* [Materials for Japanese social security, Part 1]. Tokyo: Shiseidō, 1988.

Sheingate, Adam D. *The Rise of the Agricultural Welfare State: Institutions and Interest Group Power in the United States, France, and Japan*. Princeton, NJ: Princeton University Press, 2000.

Shindō Seiichi. "Nentō no Ji" [New Year's greeting]. *Kenkōhoken Jihō* 13 (January 1939): 1.

Shō Kashin. *Nihongata Fukushi Kokka no Keisei to Jūgonen Sensō* [The fifteen-year war and the formation of the Japanese welfare state]. Kyoto: Minerva Shobō, 1998.

Skocpol, Theda. *Protecting Soldiers and Mothers: The Political Origins of Social Policy in the United States*. Cambridge, MA: Belknap Press of Harvard University Press, 1992.

Skocpol, Theda, and Edwin Amenta. "Redefining the New Deal: World War II and the Development of Social Provision in the United States." In *Social Policy in the United States: Future Possibilities in Historical Perspective,* ed. Theda Skocpol. Princeton, NJ: Princeton University Press, 1995.

Social Security Administration. "Social Security History, The Third Round, 1943–1950." Available at www.ssa.gov/history/corningchap3.html, accessed May 30, 2009.

Social Security Board. "Disability and Medical Care Insurance: An Except From the Board's Ninth Annual Report." *Social Security Bulletin* 8, no. 1 (1945): 12–16.

———. *Fifth Annual Report of the Social Security Board: Fiscal Year Ended June 30, 1940*. Washington DC: U.S. Government Printing Office, 1940.

———. "Franklin Roosevelt, 1882–1945." *Social Security Bulletin* 8, no. 4 (1945): 1.

———. "The G.I. Bill of Rights: An Analysis of the Servicemen's Readjustment Act of 1944." *Social Security Bulletin* 7, no. 7 (1944): 3–13.

———. "A National Health Program: Message from the President." *Social Security Bulletin* 8, no. 12 (1945): 7–12.

———. *Sixth Annual Report of the Social Security Board: Fiscal Year Ended June 30, 1941*. Washington, DC: U.S. Government Printing Office, 1941.

———. "Social Security for Great Britain: A Review of the Beveridge Report," *Social Security Bulletin* 6, no. 1 (1943): 3–30.

Sodei Rinjiro. *Senryō Shitamono Saretamono: Nichibeikankei no Genten wo Kangaeru*. [The occupier and the occupied: Essays on the U.S.-Japan nexus]. Tokyo: Simul Press, 1986.

Soeda Yoshiya. *Seikatsuhogoseido no Shakaishi* [Social history of the Daily Life Security Law]. Tokyo: University of Tokyo Press, 1995.

Sparrow, Bartholomew H. *From the Outside in: World War II and the American State*. Princeton, NJ: Princeton University Press, 1996.

———. "Limited Wars and the Attenuation of the State: Soldiers, Money, and Political Communication in World War II, Korea, and Vietnam." In *Shaped by War and Trade: International Influences on American Political Development,* ed. Ira Katznelson and Martin Shefter. Princeton, NJ: Princeton University Press, 2002.

Starr, Paul. *The Social Transformation of American Medicine*. New York: Basic Books, 1982.

Stein, Osvald. "Fundamental Programs." In *War and Post-War Social Security,* ed. Wilbur J. Cohen. Washington, DC: American Council on Public Affairs, 1942.

Steinmo, Sven, Kathleen Thelen, and Frank Longstreth. *Structuring Politics: Historical Institutionalism in Comparative Analysis*. New York: Cambridge University Press, 1992.

Steinmo, Sven, and Jon Watts. "It's the Institutions, Stupid! Why Comprehensive National Health Insurance Always Fails in America." *Journal of Health Politics, Policy, and Law* 20, no. 2 (1995): 329–72.

Stephens, John D. *The Transition from Capitalism to Socialism*. London: Macmillan, 1979.

Steslicke, William E. *Doctors in Politics: The Political Life of the Japan Medical Association*. New York: Praeger Publishers, 1973.

Suetaka Makoto. "Shakaihoshō Seido no Nihonteki Seikaku" [Nature of the Japanese social security system]. *Rōdō Hyōron* 5, no. 1 (1950): 2–5.

Sugaya Akira, *Nihon Iryō Seidoshi* [History of Japanese medical system]. Tokyo: Hara Shobō, 1976.

———. *Nihon Iryō Seisakushi* [History of Japanese medical policy]. Tokyo: Nihon Hyōronsha, 1977.

Sugita, Yoneyuki. "Universal Health Insurance: The Unfinished Reform of Japan's Healthcare System." In *Democracy in Occupied Japan: The U.S. Occupation and Japanese Politics and Society,* ed. Mark E. Capiro and Sugita Yoneyuki. New York: Routledge, 2007.

Sugiyama Akiko. *Senryōki no Iryōkaikaku* [Medical reform during the military occupation]. Tokyo: Keisō Shobō, 1995.

Supreme Commander for the Allied Powers, Public Health and Welfare Section. *Public Health and Welfare in Japan*. Tokyo: Supreme Commander for Allied Powers, Public Health and Welfare Section, 1948.

———. *Public Health and Welfare in Japan: Annual Summary—1949, Volume 1*. Tokyo: Supreme Commander for Allied Powers, Public Health and Welfare Section, 1949.

———. *Public Health and Welfare in Japan: Annual Summary—1950*. Tokyo: Supreme Commander for Allied Powers, Public Health and Welfare Section, 1950.

———. *Weekly Bulletin for 13–19 December 1948, Number 103*. Tokyo: Supreme Commander for Allied Powers, Public Health and Welfare Section, 1948.

Suzuki Atsushi. *Nihon no Iryō wo Toinaosu: Ishikarano Teigen* [Rethinking Japanese medicine: A proposal from a doctor]. Tokyo: Chikuma Shinsho, 1998.

Suzuki Hitoshi. "Kokumin Kenkōhoken Seido Yōkōan ni taisuru Ichi Kōsatsu" [A thought about the National Health Insurance Bill]. In *Nihon Shakaihoshō Zenshi Shiryō: Shakaihoken* [Prehistory of Japanese social security: Social insurance], ed. Shakaihoshō Kenkyūjo. Tokyo: Shiseidō, 1981.

Takei Gunji. *Kōseishō Shōshi: Watashi no Zaikinroku kara* [A short history of the Ministry of Health and Welfare]. Tokyo: Kōseishō Mondai Kenkyūkai, 1952.

Takemae Eiji. "GHQ Rōdōka no Hito to Seisaku: GHQ Rōdōka no Gunzō" [Personnel and policy in GHQ Labor Section: Overview of GHQ Labor Section]. *Nihon Rōdō Kyōkai Zasshi* 24, no. 9 (September 1982): 60–73.

———. *Inside GHQ: The Allied Occupation of Japan and its Legacy*. New York: Continuum, 2002.

Tatara, Toshio. *1400 Years of Japanese Social Work: From Its Origins through the Allied Occupation, 552–1952*. Ph.D. dissertation, Bryn Mawr College, 1975.

Tilly, Charles M. *Coercion, Capital, and European States, AD 990–1992*. Cambridge, MA: Blackwell, 1993.

Tipton, Elise K. *Modern Japan: A Social and Political History*. New York: Routledge, 2002.

Titmuss, Richard M. *Essays on the Welfare State*. New Haven: Yale University Press, 1959.

Tocqueville, Alexis de. *Democracy in America*. George Lawrence, trans., and J. P. Mayer, ed. New York: HarperPerennial, 1988.

Truman, Harry S. *Public Papers of the Presidents of the United States, Harry S. Truman, Containing the Public Messages, Speeches, and Statements of the President, January 1 to December 31, 1947*. Washington, DC: U.S. Government Printing Office, 1963.

———. "Special Message to the Congress Recommending a Comprehensive Health Program." November 19, 1945. *Public Papers of the Presidents of the United States, Harry S. Truman, Containing the Public Messages, Speeches, and Statements of the Presidents, April 12 to December 31, 1945*. Washington, DC: U.S. Government Printing Office, 1961.

———. "Special Message to the Congress on Health and Disability Insurance." May 19, 1947. *Public Papers of the Presidents of the United States, Harry S. Truman, Containing the Public Messages, Speeches, and Statements of the President, January 1 to December 31, 1947*. Washington, DC: U.S. Government Printing Office, 1963.

Uemura Kōgorō. "Genka Senji Taisei no Gaiyō" [An overview of the current war mobilization system]. *Nihon Sangyō Eisei Kyōkai Kaihō* 90 (January 1938): 8–13.

U.S. Department of Commerce, Bureau of the Census. *Historical Statistics of the United States, Colonial Times to 1970*. Washington, DC: U.S. Government Printing Office, 1975.

———. *Statistical Abstract 1952*. Washington, DC: U.S. Government Printing Office, 1952.

———. *Statistical Abstract 1955*. Washington, DC: U.S. Government Printing Office, 1955.

U.S. House of Representatives, Committee on Expenditures in the Executive Departments. *Investigation of the Participation of Federal Officials in the Formation and Operation of Health Workshops: Third Intermediate Report of the Committee on Expenditures in the Executive Departments*. Washington, DC: United States Government Printing Office, 1947.

U.S. Public Health Service. *History, Mission, and Organization of the Public Health Service*. Washington, DC: U.S. Department of Health, Education, and Welfare, Public Health Service, Office of Administrative Management, 1976.

U.S. Senate, Committee on Education and Labor. "The Experimental Health Program of the United States Department of Agriculture: A Study Made for the Subcommittee on Wartime Health and Education of the Committee on Education and Labor, United States Senate." Washington, DC: United States Government Printing Office, 1946.

———. "Report of Subcommittee of Senate Education and Labor Committee on S. 2871, to Establish an Office of War Mobilization." Washington, DC: U.S. Government Printing Office, 1943.

———. "Wartime Health and Education: Interim Report from the Subcommittee on Wartime Health and Education to the Committee on Education and Labor, United States Senate, Pursuant to Senate Resolution 74, a Resolution Authorizing an Investigation of the Education and Physical Fitness of the Civilian Population as Related to National Defense." Washington, DC: U.S. Government Printing Office, 1944.

U.S. Senate, Subcommittee on Wartime Health and Education. "Interim Report to Committee on Education and Labor: Wartime and Education, Health Needs of Veterans." Washington, DC: United States Government Printing Office, 1945.

Watson, Mark S. "To Those Who Served." The War Department, 1950. Available at www.army.mil/cmh-pg/books/wwii/csppp/, accessed May 30, 2009.

Weissert, Carol S., and William G. Weissert. *Governing Health: The Politics of Health Policy.* Baltimore: Johns Hopkins University Press, 2006.

Wilentz, Sean. "Why Is There No Labor Party? Class and Race in the United States and Austria." In *American Exceptionalism? U.S. Working-Class Formation in an International Context,* ed. Rick Halpern and Jonathan Morris. Basingstoke, U.K.: Macmillan, 1997.

Yamamoto Tatsuo. "Daijin no Aisatsu no Yōshi" [Summary of minister's explanation]. In *Nihon Shakaihoshō Zenshi Shiryō: Shakaihoken* [Prehistory of Japanese social security: Social insurance], ed. Shakaihojō Kenkyūjo. Tokyo: Shiseidō, 1981.

Yamazaki Iwao. "Relief Measures for Soldiers' Families." *Foreign Affairs Association of Japan* 6 (1938): 667–75.

Yoshihara Kenji and Wada Masaru. *Nihon Iryōhoken Seidoshi* [History of Japanese health insurance]. Tokyo: Tōyō Keizai Shinpōsha, 1999.

Zaitsu Yoshifumi. "Kenkōhoken no Shinshimei to Hoken-i heno Yōbō" [New mission of health insurance and request to the JMA]. *Shakaihoken Jihō* 17–18, no. 3 (1942): 1–4.

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